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ABSTRACT

In major presentations in these proceedings, national leaders discuss futuristic ideas about aging. An awareness of the present and future rights and responsibilities of older persons and the personnel working with them is developed in the variety of topics presented. Topics include: current practices, education, housing, law, creative life styles, income and employment, volunteerism, delivery of human services and a special interest session of programs in operation. (BN)

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RIGHTS AND RESPONSIBILITIES. . . A LOOK AHEAD

JULIE L. PECK
EDITOR

The Proceedings of the 23rd Annual Meeting
of the Western Gerontological Society
Denver, Colorado
March 20, 1977

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WESTERN GERONTOLOGICAL SOCIETY
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Dear Friend:

A high point in the history of the Western Gerontological Society, now in its 24th year, is reflected in these Proceedings. Participation in the Denver Meetings reached a new high, symbolizing both growth and permanence. It is only through the years and years of dedicated effort of many individuals who voluntarily gave of their time and energies that this momentum has been realized.

We are excited not only about the added numbers, but also about the nature of the membership of the Society. Serving researchers and academicians, professionals and practitioners, policy-makers and older Americans, experienced career gerontologists and students, we derive strength from our diversity. As we travelled through the region this fall, this diversity was clearly visible and responsible for a great variety of ideas on policy, long range planning, development of membership services, and program planning for the 24th Annual Meeting.

The success of the 23rd Annual Meeting in Denver was due in large part to the hard work of many individuals and agencies. It's impossible to name them all, but let me point out just a few. A very special thanks to Linda Devine and Bob Robinson of Denver who co-chaired the Local Arrangements Committee and gave so much of their time and energy so that nothing was left undone. Also, thanks to Paul Kerschner, Chairman of the Program Planning Committee and the regional Program Planning Chairpersons, Peter Peth, Ray Smith, and Edith Sherman, and all the others who participated without compensation in the effort to bring events and people together in Denver.

We extend a sincere invitation to you to participate in the Western Gerontological Society. If you are not yet a member, we hope you will join today by sending in the enclosed membership application form. If you are a member, we encourage you to become actively involved -- perhaps you would like to serve on one of our many Standing Committees or on our Policy Task Forces.

Above all, we would like to hear from you, since it is only through your ideas that we can continue to focus our energies on those activities and programs most useful to you.

Cordially,

Gloria H Cavanaugh

Gloria Haerther-Cavanaugh
Executive Director

Western Gerontological Society

785 Market Street, Suite 1114
San Francisco, California 94103
(415) 543-2617

Dear Colleague:

Congratulations to you -- the membership and friends of the WGS -- for making the 23rd Annual Meeting in Denver, Colorado a tremendous success. Contained in the Proceedings of the 1977 meeting, you will find evidenced some of the zeal, work, and enthusiasm which has been displayed by our Executive Director, Gloria H. Cavanaugh, and the Deputy Director, Martha Holstein, the WGS staff, Board, standing committees, Local Arrangements and the Program Committees. The meeting's success was made possible through splendid efforts of many members and professional friends who accepted invitations to serve as coordinators, resource persons, or presentors. Registration, hospitality, and housing arrangements were handled by dedicated volunteers and publicity was accomplished by publishing early announcements in Generations and through the news releases from an efficient press-room.

Volunteer agencies like ACTION and professional groups like the Gerontological Society held pre- or post-meeting workshops which expanded the opportunity for sharing information. In major presentations, national leaders discussed futuristic ideas about aging. At the Senate Hearing about the Rural Elderly, members, interest groups and individuals presented information about the organizational developments of the WGS to new regional or state organizations. An awareness of the present and future rights and responsibilities of older persons and the personnel working with them was developed.

Support funds came from organized senior groups, private contributions, registration fees and the Administration on Aging. Participants were registered from 39 states, Guam, Samoa, Washington, D.C., and Canada. They witnessed the results of the outstanding program planning, membership involvement, and presentations about applied programs. In all this, our friend, Ollie Randall, summed it up by saying there was the development of a spirit of togetherness which made it "OUR MEETING."

My heartfelt gratitude is expressed to the fine people of the WGS who morally and financially supported strengthening the attitude and knowledge base of American Aging. I trust these Proceedings will serve as a reminder of your participation and as a resource for our continued work in gerontology.

Sincerely,

W Roy Van Orman

W. Roy Van Orman, MSW-MPA
President, 1976-1977

Western Gerontological Society

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Dear Friend:

The WGS Annual Meeting in Denver was a great Meeting! The Meeting was great because of the hard work of the staff and the eager and enthusiastic participation by the thousands who attended.

The 23rd Annual Meeting in Denver was also a significant addition to the annals of the WGS because it was our first Hearing with the Senate Special Committee on Aging.

Now all I can say is that there has been enough talk -- let's get on and do it -- and by the next Meeting, April 9-12, 1978, in Tucson, Arizona, we can measure what we have accomplished.

See you all there!

Sincerely,

Marian Lupu

Marian Lupu
President, 1977-1978

Western Gerontological Society

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WGS 23RD ANNUAL MEETING

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Poster Sessions: **Eleanor Tattersall**, Alameda, CA.
Conversations With: **BARBARA BYFIELD**, San Francisco, CA & **MONICA MOORE**, Santa Ana, CA.
Evaluation: **BEVERLY CALTON**, Fullerton, CA. & **TERI DOWLING**, San Francisco, CA.
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WESTERN GERONTOLOGICAL SOCIETY
23RD ANNUAL MEETING

SUNDAY AFTERNOON OPENING SESSION
MARCH 20, 1977

The Sunday Afternoon Opening Session was called to order at 1:05 p.m. o'clock, in the Grand Ballroom of the Hilton Hotel, Denver, Colorado, Mr. W. Roy Van Orman, President, Western Gerontological Society, presiding. . .

PRESIDENT VAN ORMAN: My name is Roy Van Orman, this year's President of the Western Gerontological Society, and I would like to extend to you a very warm welcome to the conference that is being held these days.

As we begin our conference, I have some announcements for those of you who have pens and paper and who want to put some of these into your notes, and then you will be ready when you hear some of the remarks later, and you will already have this business taken care of.

One of the continual questions that comes before us in the Western Gerontological Society is "What is it?" If you have not had that question yourself, let me give you the answer anyway. The Western Gerontological Society is a society of professionals, volunteers, service delivery personnel, and others who have a high interest in the development and carrying out of any kind of program that reaches older people. The majority of our geography is covered in Health, Education and Welfare Regions 8, 9, and 10, but is not restricted in that area as it pertains to membership. There is a difference between the Western Gerontological Society and what some people call the Gerontological Society which is together on a national level. We are the Western Gerontological Society and we have different boards of directors, we have different presidents, and subcommittee chairpersons, and standing committee chairpersons. We have a different focus. Our focus is in the application, in the way that it can be used by all of our membership and older people in the Western United States.

Those of you who have registered for this conference, if you find that you have a little green leaf stamped on the corner of your name tag, this says I am saying thanks to you for paying your membership dues. If you don't have a little green leaf, we are saying to you for only five dollars more than you have paid already, that could quite easily be blanketed in. So, recognizing that small difference in fee, we would be quite honored to have you as a member in this organization, and I would encourage you to go to the membership sign-up places out in the registration area and be a card-carrying member of this organization. We have made a special effort this year to have available cards that you can carry in your wallets just in case someone wants to ask you for identification.

There are publications that are available as far as the proceedings from last year's meeting that was held in San Diego. I would encourage you to purchase a copy of that. We would like very much to sell all the copies so we don't have to carry them back to San Francisco, and also so that you may share the volume of information that was presented in workshops, in the conference proceedings and in the dialogue that went on at the San Diego meeting. We feel that it is a very valuable contribution to you for your libraries and as a resource as your work further on programs.

On Wednesday, there will be a hearing on the concerns of the rural elderly which will be put on by the Senate Special Committee on Aging. We will have Senator Church conducting the hearing, and we will have Mr. Bill Oriol and the staff of the Committee on Aging conducting that.

I want to thank publicly the Grey Panthers and other local groups in the Denver area for assisting the Western Gerontological Society in raising a public consciousness about the needs and the concerns of our older population.

We have on the stand with us today Dennis Gallagher, from the Colorado State Senate, to make a welcome from Colorado.

SENATOR GALLAGHER: Congresswoman Schroeder, Honored Guests and Friends: It is a joy to be here to welcome you to our beautiful city of Denver. In the musical, "The Unsinkable Molly Brown," you might have remembered the song called "The Beautiful People of Denver," and Denver is a town full of beautiful people. It is said that people in the downtown area wearing these badges from conventions near the Hilton Hotel can stand on a street corner with a quizzical look and three Denverites will come up and argue over which way is quicker for you to get to your destination. (Laughter) But we must warn you that we do have some Philistines among our midst. So be careful. (Laughter)

I would like to welcome you to Denver, to this lovely city. Now, we want you to go to every one of your sessions and be very faithful about going to your sessions, but if you do have some time away, there are some lovely little ethnic restaurants in this city, all over town, of various kinds. If you want to talk to me about any of them and, if you like, as we are walking through during the week and if you see me, just ask me and I will give you some of my favorites.

Also, we would like to welcome you to the beautiful State of Colorado. There's an old song about Colorado:

"Way out West at the foot of the Rocky Mountains,
There lies a place like a jewel in the sun
Where snow gleams and glistens and God stops to listen,
And fish are jumping high as an aspen tree.
I know of no other place I'd rather be."

We hope that's true of you with this convention this week. We hope your convention is a fruitful one. We hope that you enjoy your sessions, and turn all these theories that we're talking about into practical realities.

Welcome to Colorado.

PRESIDENT VAN ORMAN: That has been the feeling since we started thinking about coming to Colorado with these sessions.

I would now like to turn the microphone and the time to Congresswoman Pat Schroeder from Colorado to get on with the business of why we are here today.

. . .Congresswoman Pat Schroeder of Colorado assumed the chair as Moderator. . .

MODERATOR SCHROEDER: Thank you very, very much, and I, too, want to add to Dennis' welcome to all of you. I am a little disappointed, because I had made a rabbit suit for Dennis, and I was hoping he would surprise us all and come in his spring costume, but he didn't quite do that.

We have a tough job for the next couple of hours, because we have to keep you awake between the hours of one and three-thirty on a Sunday afternoon. I don't know about your house, but that is one of my favorite dozing times at my house. But I think we have a very, very interesting program, and I think it will do more than keep you awake.

We are going to have an address by Michael Harrington, as you well know, and then we have some snarling, snapping dogs up here that get to take their first bite out of him, and then it's your turn. You get the next bite. So take notes and feel free to come forward with all sorts of interplay.

One of the things that I hope we can really focus on in this convention is how much aging impacts on women, and I think that is one of the reasons I have always been very, very concerned about the whole aging process. We now know that the fastest-growing poverty group in America is female. That is because we live longer, and any discrimination in Social Security or anything else impacts the heaviest on women when they get into their senior years, and many of them who have never been impoverished before suddently find themselves living in an incredible manner in which they never dreamed they would have to live. So that really impacts upon women.

There's another thing. Not only do we live longer, but men in our society sometimes remind us we are aging every single day after we have passed our twenty-first birthday. I work in the Congress of the United States where most of the gentlemen are older than I am, and every day they come by and make some comment about, "Well, lady, you really are looking bad—two more gray hairs," and I want to hit them! It's kind of like if you are not an eighteen-year-old chickie baby, as a woman, you're over the hill. I am always saying to people, "The problem is men age and women rot." (Laughter) Well, I don't agree with that, and I think it's time we have a little more open discussion about that, that we are not all over the hill by the time we're twenty-one and we want to participate and be treated with a little more respect on some of those issues. It's kind of a sensitive spot, I think, for a lot of us. So I think it is going to be a very, very good conference. I commend you tremendously on the city you have selected.

And now I want to introduce you to the raw meat that we are all going to get to pick at after he gets done with his speech.

I don't think Michael Harrington needs much of an introduction. He has been one of those marvelous people who has been out front really making us think about an awful lot of things. It's very easy to go lie under a tree and have a lemonade and tune it all out. But there has been a certain gruop of thinkers, such as Michael Harrington, who have been out there constantly questioning, probing and writing. He is one of the most lucid writers I know, and I have enjoyed many, many of his books.

He's the Chairman of the Democratic Socialist Organizing Committee. He has written many books which I am sure you have heard of: "The Other America" "Socialism," "Fragments of the Century," etc. But I think the main thing is that he has been a real political activist. He almost wrote the book on political activism, and he has taken some very tough stands. It's not exactly popular in this country to be a socialist. Many people have been accused of being closet socialists. No one can accuse Michael Harrington of being a closet socialist. He has come out of the closet and said "I am a socialist," and has really espoused some ideas that have made people stop and re-evaluate their premises and think.

If it is usually your naptime on Sunday afternoon, I hope we will try to be alert and take in some of these ideas. Then we will start the panel discussion and I will introduce the panel to you at that time and we will have at it.

So, Michael, welcome to Denver. We are delighted to have you.

MR. MICHAEL HARRINGTON, Chairman of the Democratic Socialist Organizing Committee: Thank you very much, Pat. Norman Thomas used to say, after an introduction like that, that he looked around for the coffin. (Laughter)

The theme I would like to present to you today is that aging people in the United States have made some significant gains in the last twenty years—and I think that it is a mistake not to recognize the gain—but that there are new attacks on the position of the aging, that there are great difficulties which I am afraid we have to see in the future. Therefore, I come to a policy conclusion which I will state now and then restate at the end of my remarks.

The policy conclusion is that the aging and those who work for the aging in the United States cannot confine themselves to the so-called special interest programs of people over sixty-five, but if the aging are to continue making gains, they and their supporters have to be concerned with the larger society, have to make coalitions with other groups and, in particular, I want to suggest to you, have to be concerned with an issue that doesn't sound like an aging issue at all—the issue of a full employment economy.

Let me try to develop that. I'm not going to lecture you on what you know so much more than I. I am going to try to lead from my own strong suit. I want to do it in three ways: first of all, to talk about the current attack on the welfare state and to relate it to the aging in the United States; secondly, to talk a bit about the position of the aging in this society, particularly from recent analyses and discussion of the problem of poverty; and, finally, to come to my policy conclusion which I hope will follow from that analysis; that is to say why I believe the aging and their supporters must form coalitions, must focus on issues like tax reform and full employment, as well as the special issues affecting the aging.

So first of all, the attack on the welfare state as it particularly relates to the aging. I would date the current attack on the welfare state to the day after the 1972 election and an interview which Richard Nixon gave to Garnett Horner of *The Washington Star*. In that interview, Nixon brought out some themes which I think, even though Nixon has been retired from public life, still dominate our discussion of these issues. In that interview, Nixon coined the famous phrase, "In the 1960's, we threw money at problems. In the 1960's, we acted as if the government could do everything. In the 1960's, we became too permissive and gave people too much. And, therefore, what we have to do in the 1970's," said Nixon, "is to retreat from that, is to think smaller, is to lower our expectations." And what this was was an attack on the welfare state.

Now I would like to look at that attack and analyze it from three different angles. First of all, what Nixon was saying about throwing money at problems was not really true. Are you aware (and here you can find it documented by the Joint Economic Committee last year) that the federal bureaucracy per capita has not grown at all in the last twenty years? Are you aware that the percentage of the Gross National Product that the government spends has not skyrocketed, but it has gone between 17-20% of the GNP for the past twenty years, and, indeed, under Gerald Ford, it went up. Do you know why it went up? Because the GNP went down and there were all kinds of unemployment and food stamp costs that went up, and, therefore, it was not the profligacy of the welfare state that caused the federal spending to go up: it was the failure of the Nixon-Ford Administration to achieve full employment. So we didn't really spend all that money. But, secondly, in relation to all this, and here is where the aging begin to enter in, do you know where most of the money went that we did spend? Two-thirds of it went to the aging—two-thirds of the new spending in the 1960's. Specifically, it went to Social Security increases in Medicare. Indeed, if you look at the welfare state, you discover a very interesting fact. The main beneficiaries of a welfare state in terms of dollars spent are people over sixty-five years of age. What I am suggesting is that, therefore, when there is an attack on the welfare state that says the welfare state is a failure, that the welfare state is something that we ought to cut back on, don't think that it is an attack on something terribly radical. It's at attack on Social Security. It's an attack on Medicare, because, in fact, in the 1960's we did not engage in radical innovations. We sometimes talked as if we did, and the American people heard many of the bold speeches about how they were going to remake the society. They then noticed that the society is not exactly remade, and they assumed that we failed because we did so much. What they don't know is that we didn't act on many of those speeches.

Daniel Patrick Moynihan, in his book on the guaranteed annual income, said, "The programs of the sixties were oversold and underfinanced to the point that their failure was almost a matter of design." So, No. 1, Nixon said we spent too much money. We didn't really spend too much money. No. 2, Nixon said we were too radical and we weren't too radical. No. 3, Nixon said that many American people believed that the money we spent was badly spent. But the fact is, and this is where the aging comes in again, the bulk of that money went to Social Security increases in Medicare. And with all the problems in both programs, I suggest to you it was money well spent: that is to say that the position of the aging in this society is not what it should be, but as a result of spending that money, it is better than it was. And the idea that this is radical strikes me as almost amusing when you think that Medicare is a partial installment on the national health insurance we should have for everybody in this society. (Applause) And in the area of national health, my radical left-wing program is that the United States, on the one hundredth anniversary of national health in the Kaiser's Germany catch up with the Kaiser's Germany (laughter), because in the area of health we are about one century behind.

What I am saying in this first point is that here is all this misinformation. Walter Heller, who was the Chairman of the Council of Economic Advisers under John Kennedy, said, "This information is not accidental. It is misinformation to misguide the public. It is an attack on the welfare state." I am suggesting to you that the attack on the welfare state is an attack on the aging, and that, therefore, the aging, in addition to everything else, have to respond politically to this miseducation with some positive education.

Now, the second major point related to this. There is a new attempt in this country to define poverty out of existence. We play a new game in Washington. One way to solve a social problem is to define it statistically so it doesn't exist any more. (Laughter) I'll give you an example of this. By the way, let me state frankly I voted for Jimmy Carter. I have no regrets about voting for Jimmy Carter. If I say critical things, it is within the framework of a feeling that it is much better to have Jimmy Carter as President than Gerald Ford. But I am critical. And within that context, Charles

Schultz, Mr. Carter's Chairman of the Council of Economic Advisers, is now talking about defining full employment at 5% unemployment. (Laughter) Under John Kennedy, it was 3%. Under Lyndon Johnson, Nixon and Ford, it was 4%. Now we define it as 5%. And if we just keep raising the ante, we will statistically achieve full employment (laughter) while millions of people are out of work. (Laughter)

This is also being done with poverty, and this relates very much to the aging. In 1975, Gerald Ford's Council of Economic Advisers suggested that the poverty definitions are too high, that we have been overestimating poverty, and the main reason that Allen Greenspan & Company said that this was the case was that we did not count in-kind income in assessing the income of the poor. We only accounted the cash income of the poor. We didn't count in Medicare, Medicaid, rent subsidies, ownership subsidies, etc. That was taken up by the Congressional Budget Office this year, and the Congressional Budget Office discovered (this is one of these marvelous statistical gimmicks) that while the Bureau of the Census said that poverty was increasing by 11%, the Congressional Budget Office, by fooling with the numbers, managed to cut it in half. And indeed then an article in "The Public Interest," in the old conservative magazine, came up with the point that poverty in the United States doesn't exist any more.

Now, how is this done? It was done, in part, by gimmicks. One of the gimmicks was to take all real or alleged possibilities of overcounting of the poor and weight them very heavily, you ignore all undercounting of the poor, and then you come up with a new definition. The woman who defined the poverty line for the government, a marvelous woman by the name of Molly Orshanski, did a computation in which she took both into account and her figures doubled the number of the poor rather than cutting them in half. One of the interesting things, by the way, is if you ask the average American in the street, "What do you think the poverty line should be?", their figure at this level increases the number rather than the Congressional Budget Office level which decreases it so radically.

What does it have to do with the aging? It has very much to do with the aging because they are the fall guys and girls—men and women—for this statistical gambit. When you say that you count in the in-kind of value of what people get and charge that against their living standards, what do you define as the in-kind value? How do you give it a number? And the government's answer was it's what the government spends. What that means is that people in Medicare have attributed to their living standard all the money ripped off from the program by the various people who are ripping it off. (Applause) That is done so that their living standard goes up. In other words, the enormous increase in the doctor's income is charged to the patient in the statistical method.

Secondly, there is an incredible anomaly. Obviously, one of the problems of the aging is medicine. And do you realize that by this new poverty definition an aging person can enter the middle class by having a catastrophic illness? (Laughter) If you are lucky enough to get really sick and have $20,000 in fees spent on you by the Federal government, you've got a $20,000 income and you beat the median income all hollow and you're practically heading up toward the middle class. (Laughter)

Thirdly, and related to this, and I think this is another thing where people have to be aware of the larger dimensions of the problem of aging, much of the medical expenditure for the aging is spent on terminal care. Now that's a gain and I don't want to denigrate it. It is obviously better that the final time of people on earth is spent in some dignity. But what it's done is that that money is statistically shifted to the aging as a whole so that you can have, as one expert said to me, the aging getting their last month on this planet in some kind of decent and dignified shape, but that the rest of the time, they do not, that they have to be ready to die before they can get some of these statistical benefits.

In saying these things, I want to come to another proposition. The proposition is that we have made some success with the aging, I think that those of us who are critical of these gains should not say that no gains have been made. Poverty among the aging has been somewhat reduced, not enough, but somewhat. Indeed, I would like to say to Mr. Nixon and those who bought his proposition that there is one problem that can be solved by throwing money at it. That problem is having enough money. (Laughter) That is to say if you have someone who is aging and who doesn't have enough money and you increase Social Security benefits, you index problems, but you are solving one of their problems. Now, the poverty of the aging is so terrible, it's so intolerable, we could end the poverty among the aging tomorrow morning at nine o'clock if we politically wanted to, and we could do it simply by setting the benefit levels at an adequate income in life for the aging, Again, that would not solve generational apartheid that we have in this society. It would not solve many other problems. But it would solve an enormous series of problems.

Therefore, I want to suggest a second major point. Most of the aging, by the government's definition, are not poor, although I think many more of the aging are poorer than the government concedes. But what I want to suggest is that the aging who are not poor have a very deep stake in seeing that justice is done to the aging who are poor, because this is again part of the whole effort to discredit the welfare state, part of the whole effort to discredit future increases in Social Security, future investments in medical care, etc., etc.

Finally, as a third major and last point, all of this relates, I think, relates profoundly to the question of full employment. I now want to take the concerns of the aging and widen the focus even beyond those issues which immediately concern the aging like these phony statistics that I have been talking about. Demography is one of the most inexact sciences known to man. There are some U.N. projections on the world population in the middle of the twenty-first century where the highs and the lows have variations of five billion people. Give or take five billion people we will have so many people in the world. That's a pretty big give or take. But even though demography is inexact, I think we probably have to deal with the trends in American society that the proportion of the society—the famous rectangle trend—that is older is going to increase because the birth rate has already slowed down. And therefore you are going to get in situations in the future where you are going to have, in relative terms a smaller work force which is going to have to generate the income to take care of a relatively larger aging population. That, it seems to me, is a fundamental new structural problem that anybody concerned with the conditions of the aging in the United States has to face up to, and let me say a couple of things about it because I think in that situation there is a capacity for enormous resentment between the population that is working and the population that is retired—a resentment that can have very serious political consequences for the aging.

If you looked at *The Denver Post* this morning, you might have noticed an interesting column by Sylvia Porter on Social Security taxes. She didn't go the whole route: I'll do that. I think she raised some very interesting points. One is this: The Social Security tax portion of total federal revenues is now 25%. Twenty-five percent of the money the government gets is from Social Security tax. In 1957, it was 8.5%; in 1947, it was 3.5%. So the cost of Social Security on the employed has been going up as the percentage of federal revenues.

Secondly, something that Sylvia Porter does not mention, is that the increase in the Social Security elements of federal revenue has been mirrored by a decrease in corporate tax revenue. Personal income tax has stayed about the same, Social Security has gone way up, corporate tax revenues have gone way down. I am saying that given that, you have to look at one further thing. That further thing is that the social security tax is a paradoxical tax. It is simultaneously the most regressive and the most popular tax in the United States of America. As a people, you hear people complaining about their federal income tax, and you rarely hear them complaining about their Social Security tax. The reason is most people wrongly think that Social Security is an insurance system that you pay into and receive benefits from in ratio to what you pay in. That's not the case, but most people think that and this appeals to the deep conservatism of the American spirit which I think, by and far, doesn't want welfare and regards welfare as being demeaning. People feel, "Social Security is something I put in and, I get paid out for. I get something for it," but they don't realize that Social Security is terribly regressive. I am sure all of you know why it is, but right now, somebody who makes $500,000 a year pays the same Social Security tax as somebody who makes $16,500, and that means that Social Security is a terrific deal for the upper middle class and the rich, but it is an increasing burden in terms of payments on working people. That means, I suggest to you, that those who are concerned with the problems of the aging have to be concerned about tax reform.

One of my favorite lines from Jimmy Carter's acceptance speech at Madison Square Gardens was that the Internal Revenue Code is a disgrace to the human race. I agree, because not only does it contain this kind of thing, it contains what they now call tax expenditures where you now have 106 billion dollars in the 1977 budget given to people in the form of not requiring them to pay taxes. In other words, if you make money in this society through selling capital and making capital gains, your income is taxed at a lower rate than if you make money working. Somebody who sells G.M. stock has a lower tax rate on that sale than the worker who made the car that gave the G.M. stock its market value. So here you have this: a tax system that has this regressive Social Security tax, that under this demographic condition that we are talking about could create tremendous resentment among working people directed against aging people. And as part of the problem (and I am dealing with a very complex problem very briefly), I think we should pay for Social Security out of general tax revenues raised through a progressive federal income tax that would take the rich off of welfare rather than reducing the expenditures on the aging and other people in the society. (Applause) I don't think that's enough, because I don't think we can solve any problem in this society, including the problem of aging or deal with it, unless we have full employment. Let me tell you why. First, let me leave the aging until last. Let me just kick off the other groups for whom full employment is key. We are ot going to get disarmament in this society if workers in the defense industry have to view disarmament as a threat to their livelihood. We aren't going to get it. I don't think that the defense worker should be made to pay the cost of peace. I think the answer is to provide socially useful jobs of peace for defense workers, but to do that because this is a public sector area we are dealing with which requires full employment. We are not going to get economic justice for the minorities in this country who receive two-thirds of the white wage as long as there is this kind of unemployment, because they are the last hired, the first fired. They are suffering a depression now, not a recession. There are areas where the minority youth are suffering unemployment rates of 40% or 50%. We are not going to get justice for women who also only get two-thirds of the male wage because women have been disastrously hit by this high unemployment. And if we do what Charles Schultz is now doing, defining full employment at 5% unemployment, say that it is an inflationary danger when we get to 5.5%, what that says is that we are going to have to have for this system to work what Karl Marx called a "reserve army of the unemployed." I find it very strange that people with conservative points of view are making an impeccable Marxist point that American society can only work without inflation if there are millions of people out on the street.

Now, the obvious victims of that process are the minorities, the women and the youth. I would like to add a fourth category—the aging, because if we begin to tolerate chronic high rates of unemployment in this society, we will not have the output to generate the revenues required to take decent care of that relative increase in the number of aging people relative to the number of working people. I, therefore, want to say to you I don't think the aging people in the United States can solve their problems, can get the Social Security they deserve, the medical care they deserve, the other help that they deserve, unless there is a full employment economy.

So I want to say then that at this conference I noticed by your program, which strikes me as remarkable and comprehensive, that you are talking about all the various special questions of the aging. By all means, we need advocacy on that. You know more about that. I don't want to tell you anything about that. You tell me. But what I want to also suggest to you is to put the problem of the aging in this larger social economic context. I think that's very important.

And I suggest to you as you deliberate, that you think about the relationship of the problems of the aging to the welfare state, the relationship of the problem of the aging to these new definitions of poverty which are often made at the expense of the aging, the relationship of the aging to the problem of full employment. I think what I'm saying is this: that one of the concerns that all of us have is that the aging be brought out of the ghetto, out of the apartheid that this society imposes upon them so often. I think we have to do it, but I want the aging themselves and their advocates to be coming out of the ghetto from their way, too, and one of the ways is to say, "We are part of a larger coalition of trade unionists, minority activists, feminists and reformers who are concerned not simply with these specific and special programs for the aging, but who are concerned with a full employment society which will do justice for all, including the aging. We, the aging, are not the special interest in the United States; we are a part of the general interest." Thank you. (Applause)

MODERATOR SCHROEDER: Absolutely marvelous, and I don't think there is anyone in the world who could have slept through that. We probably ought to take out our crayolas and make our picket signs now and go. (Laughter) In the interim, let's not part with what's on the program. So I guess we have to proceed with where we were.

I think what I will do is first generally tell you who is on the panel, and then I will call on each one of them in order to make their initial comments. Then we are going to open it up to you, I'm going to be kind of an umpire until about three o'clock and then at three o'clock I have to make a plane unfortunately or I won't make it back to Washington.

Someone else will take it over to finish the umpiring until three-thirty. I think the give-and-take can be very exciting also.

The first panelist you are going to hear from when they start is Ollie Randall. I doubt that any of you need to be introduced to her. She is absolutely a marvelous woman who has more energy in her little finger than most people have in their whole body. She was one of the original founders of the National Council on Aging. I was going to read you all of her awards and all her honorary degrees, and then I thought the best thing to do would be to read the ones she hasn't gotten and I couldn't find any. So all I can say is that she has really made this whole area a tremendous advocacy of hers. She has been incredibly dedicated and has set a tremendous role model for every single one of us. You feel lazy just sitting there and watching her, because she really does seem to be endowed with phenomenal energy.

Then the gentlement sitting over here next to me is Dr. Flemming whom many of you know is the United States Commissioner on Aging. He is also the Chairman of the United States Commission on Civil Rights. So he brings a lot of these interests together.

He received his M.A. from American University and his Juris Doctorate from George Washington. Again, I could read you the list of things he has done. All the panelists are this way. Their resumes all weighed in at about five pounds. But I think we really want to move on to the substance of it so let me just say he's really been very involved in different White House conferences on the aging and he's been involved in all sorts of different areas that have concerned the aging and where they are going.

Carl Eisdorfer is very, very "in" at this time, because he's even got boll weevil connections and those are very big in Washington at this time (laughter), because he spent some time at Duke University. He is currently the professor and Chairman of the Department of Psychiatry and Behavioral Sciences at the School of Medicine in Seattle, Washington. So we are very, very proud to have him with us today. He has phenomenal medical credentials; he has phenomenal interests. And, again, he has a five-pound resume of all sorts of things he has done, and he has really been very much into psychiatry, behavioral sciences and things affecting the aging and many other areas.

Then lastly we have Dr. Cohen. He is the Chief of the Center for Studies of Mental Health of the Aging. That was established in August of 1975, so it's just had a recent birth. It's at the National Institute of Health in Washington.

He has been a graduate of Harvard College and Georgetown University School of Medicine.

He is a member of the Committee on the Aging, of the group for advancement of psycbiatry. He is on all sorts of other boards, too.

At this point, I think what I am really saying to you is that they all have phenomenal credentials and have all set tremendous roles for all of us. I think as we get older, we always realize the we always realize that the most precious thing any of us have to give is time, because once you give your time you may never get it back. You may get money back, you may get anything else, but if you give your time, that's it. You don't go around again. And these are all people who have given phenomenal amounts of their time, knowing full well that same thing, that they are never going to get it back. But it's mainly because they care. So often we get hung up on our individualism in this society that we forget to care about some of the collectivism that we should be caring about which I think Michael Harrington was addressing. These people have been excellent role models and I think it will be marvelous to hear what they have to say and their lead-off comments, and then we will open it up to you.

So, Ollie, if you care to lead off and make some statements about Michael's address, we will be delighted to hear from you.

MISS OLLIE A. RANDALL, Pioneer in the Field of Aging: Thank you. I think, for the first time in my life, I am at a loss for the right words. I can't tell you how much I appreciated your presentation.

I am going to be historical for about one minute, because I worked in Washington helping to draft the Social Security Act, and our dreams about what that would mean were really tremendous. I worked with Mr. Hopkins and Mr. Roosevelt, Madam Perkins, and all the others. This was going to solve our economic problems, wasn't it? That was what we thought. And when we look today at the complications that have developed, I think many of us feel that our dream has become a nightmare. But I think your analysis here of some of the problems may, with a group like this, give us some notions of how we, as the older section who are most affected, ought to coalesce and get together and get our positions clear. Nobody can do it alone. Am I right? I have a feeling, as I look at this room, that practically everybody in the room has to be interested in what this is going to mean now and for those who are still young enough to look forward to old age, not look back on it the way I do. (Laughter and applause)

I think we have heard one of the best things that I have heard on this whole situation, and I would like to ask just one question here and then let us turn this into discussion. Do you think that the plan for possibly doing away with mandatory retirement would have any effect on the situations of the individuals as well as on the use of the Social Security program? This is being suggested and I happen to believe in it because I think none of us should be retired on the basis of years alone. (Applause) And I would like this thought thrown in: that we want to work at the right think so long as our capacities make that possible. Right? Thank you. (Applause)

MODERATOR SCHROEDER: Thank you. Would you like to pick up on that?

MR. HARRINGTON: Yes, let me just very briefly. Two things. One is I completely agree with you that mandatory retirement is bad, but I think it relates exactly to what I was saying. As long as you have this chronic high unemployment, one of the solutions the society is going to adopt, I guarantee you, is to force older people out of the labor market to make room for younger people.

The second point, I would make is although I think mandatory retirement is bad, there is another aspect of it which has been raised by the United Automobile Workers, and I think it's very important. A lot of the older workers in the UAW want early retirement. What I am saying is I think that what we should do is to maximize choice because a lot of people want to get out of that automobile shop. They don't want to be hanging around there one minute any longer than they have to. And to maximize choice, I think both things require a full employment economy.

MISS RANDALL: I agree with you on that. I used to work for the UAW for five years, and we worked out retirement programs hopefully to recognize this feeling on the part of the workers.

How many of us are still working? (Hands raised) Now, you see, this is very interesting to me.

VOICE FROM THE FLOOR: Do you do it for a paycheck? (Laughter)

MISS RANDALL: I don't think it has to be for a paycheck. Somebody asked me if that was only for a paycheck. I don't think so entirely. The only thing I ever retired was my paycheck. (Laughter) So now I work harder than I ever did and have had a better time at it it. But what I am trying to say here is that there has to be some satisfaction in your work beyond the paycheck, and for many of us older people we have to find out what that is and how to get it.

Now I remember when we drafted the Social Security Act, and when it was first drawn the age of mandatory retirement was to be seventy. This was the first draft of the Act. Then they studied the statistics and it didn't take enough older people out of the market. So the Act was then changed to sixty-five because Mr. Bismarck decided that was a good age to do it in Germany. They didn't live to be sixty-five in Germany, so he didn't have to worry. (Laughter) What I am saying here is that at that point the age of sixty-five was taken because we wouldn't remove enough older people from the labor market if we put it as seventy, and we were trying to hold jobs for the younger workers. (To Mr. Harrington) Do you remember this? (Laughter) He's a lot younger than I am. But I think it is important to keep in your minds that some of the reasoning at that point was that we were trying to develop a program that would provide supplementary income to older people on a basis of earnings which made it acceptable to them to do away with some of the welfare things that have developed so much more since. Thank you.

MODERATOR SCHROEDER: Thank you very much. Dr. Flemming?

DR. ARTHUR FLEMMING, U.S. Commissioner on Aging: First of all, I would like to express to Mr. Harrington my deep appreciation for his challenging and stimulating presentation.

In addition to some of the other issues that he identified, I would like to comment on a current trend in the direction of determining the value of in-kind service, and then using that for the purpose of making everybody feel better so far as the number of persons who are below the poverty threshold is concerned. Personally, I feel that in the field of aging we have got to keep uppermost the objective of doing everything we possibly can to increase the annual cash income of older persons to the point where they are at least over the poverty threshold. And I think also that we want to do everything we can to increase the annual income to the point where older persons do not have to suffer the indignities, for example, of a food stamp program. (Applause) I don't want to be misunderstood. I know that as of the present time we have to have a food stamp program, and I am not sympathetic with those who want to curtail that program at the present time. We've got to have it because of the fact that we still have at least 16% of the older persons below the poverty threshold along with other age groups in our society. But I continue to resent the fact that the food stamp program makes it possible for persons to stand on the sidelines, watch older persons use their food stamps and then criticize them for the manner in which the food stamps are being used. (Applause)

As we begin to mix the so-called in-kind values with annual cash income, it seems to me that we are going to postpone indefinitely raising annual cash incomes to the point where older persons will not have to utilize a food stamp program.

So I am in complete agreement with Mr. Harrington in his criticism of this current approach, and I think those of us in the field of aging have got to watch. This is one of these overall issues to which Mr. Harrington referred to which we definitely have to relate ourselves and do everything that we can to make sure of the fact that the country isn't fooled by this particular device.

I certainly concur with Mr. Harrington, as I am sure most of us in this room do, that a great deal of progress has been made in assisting older persons over the period of the past, let's say, five to ten years. But I also concur with his feelings that the overall situation is still an indefensible situation. We have already identified one aspect of it: namely that we have got 16% or so who are below the poverty line.

The labor force participation on the part of older persons continues to decline, and I want to say a little bit more about that. In situation after situation, older persons do not receive their fair share of the resources that are made available for federal programs. Only 6% of the participants in community and family health centers are older persons. Less than of general revenue sharing funds are used for services for older persons. Only 3% in adult education courses are sixty-five and over. Of those, 30% of those who are the victims of illiteracy are sixty-five and over. Less than 2% of the persons receiving vocational rehabilitation services are older persons. Less than 10% of the $2.5 million that is spent for services under Title XX goes for services for older persons. In short, whether we are talking about employment opportunities or whether we are talking about the delivery of services, older persons are the victims of agists, and agism has the same roots as racism and sexism. (Applause)

As some of you know the Congress directed the Civil Rights Commission in the latter part of 1975 to make an indepth study on discrimination on the basis of age in the delivery of services that are supported in whole or in part by the Federal Government. We are in the midst of that study now. We will be holding public hearings on it. There is no doubt at all that the evidence that will be put on top of the table as a result of that study will demonstrate that older persons time and time again are not getting their fair share of the resources that are now available in this country for various programs.

I am in complete agreement with Mr. Harrington in his feelings that we who are working in the field of aging should be deeply concerned about and interested in and committed to the concept of full employment, and I also agree with him when he deplores the gradual lowering of our sights. Instead of raising our sights, we seem to be in the process of lowering our sights. I also feel that as we talk about moving toward this objective of full employment that we have to keep in mind the fact that we not only have to introduce additional resources that will open up opportunities for employment, but that we also have got to deal head on with discrimination on the basis of race, on the basis of sex and on the basis of age.

I agree with him when he said we ought to be interested in full employment, because the more persons who are employed, the easier it is going to be to finance some of the programs on which older persons are dependent. He refers to Social Security as an illustration, and he also refers to Medicare as an illustration. But when we say that, I still hope that we are not going to rule the older persons out of that labor force. We have got to keep working on opening up opportunities for older persons to be involved in the life of our day in a significant manner. Testimony was given before the House Committee on Aging just ten days ago dealing with this question of compulsory retirement, and introduced in evidence was evidence from the American Medical Association that points very clearly to the fact that where persons are not involved there is a rapid mental and physical deterioration. We have just got to make sure of the fact, as we work toward this concept of full employment, that we don't rule out older persons. Many of them are capable of continuing to be involved and should continue to be involved. (Applause)

MODERATOR SCHROEDER: Thank you very much. Carl?

DR. CARL EISDORFER, Professor and Chairman, Department of Psychiatry and Behavioral Sciences, University of Washington: When I was called on the program to follow Mr. Harrington, I had some trepidation, but because of some pressure, I acceded. No one at the time told me that I was also going to follow Ollie and Commissioner Flemming. Had I known that, I might not be here. Being one of the anchor people in a situation like this is really very complicated. At the outset, the impulse is to stand up and applaud and cheer certainly everything that Mr. Harrington said. I agree with all the words, but I've logged some time in this field, too. I don't quite have the maturity or seniority of an Ollie or Commissioner Flemming, but I do hold this distinction. I am the only member of the Federal Council on Aging who was fired for having spoken up and said that the poverty level was absurd and that we had to use a median income level, that the notion of double-dipping was absurd and the reason we double-dipped was because there wasn't enough in the first dipper (laughter), and that the notion of a welfare state I find offensive because we are not talking of a welfare state: we're talking about one country. As soon as we imply that a group of people deserve more, we are saying we are going to be good guys and give those poor s.o.b.'s some extra for them to be nice.

So I thinkawthink we have to start off with challenging some premises. Don't applaud yet. You might boo me when it's all over.

I am very delighted that Mr. Harrington is here. My other impulse is to thank God and we should we delighted to have somebody of your caliber join us. But then, again, being a psychiatrist, you are always slightly paranoid (laughter), and you always have to raise some very interesting things. You know, I spent all day Thursdayat the Washington County Superior Court, because the Washington State Teachers Association was trying to break the state's compulsory retirement around a teacher who happens to be sixty (The testimony is all over and I think the decision will be rendered on Monday morning) who, by all indications, is just a superb, marvelous human being who has devoted her life to teaching the third grade. She didn't teach in the high school because she felt that the real action was at the third grade and that the problems she saw in the high school were because there weren't enough good elementary school teachers. She never had a master's degree because a master's degree meant that she would get too much money and the county wouldn't employ her. So she has 168 graduate credits but no master's degree. (Laughter)

Now we are talking about full employment. Do we really mean full and would full include her, or do we mean fuller to include everybody who really wants to work and has the capacity to work? And when was the last time that a union said, "Let's develop a program for employing the over sixty-five instead of the less than fifty-five?" (Applause)

So my notion is that before we join forces with all the good guys, let's make sure what the nature of the contract is. Let's make sure that the good guys who have been anxious to drop Social Security from sixty-five to sixty-two and from sixty-two to sixty and to be happy to have us retired at fifty-five, but who, at the same time, are concerned about the enormous output in Social Security income, let's make sure that they are all with us and that we are all talking the same language when we talk about full employment.

I am particularly concerned, because Mr. Harrington accepts that while things aren't good, they are getting better. I accept that, too, but I don't think that that's saying very much. To say, for example, that we are putting a lot of money into the care of the dying implies an attitude toward aging that I really don't think he feels and I sure as hell don't think anybody in this group feels. I think we have to do one other thing that we haven't done which is to say, that, relating to the Pogo cartoon, "We met the enemy and they" is us. We are looking at the aging process and that is us. How we choose to define aging, how we choose to define a welfare state, how we choose to define employment, how we choose to define dying "is us." Ladies and gentlemen, I have a terrible medical diagnosis to make for you: Everyone in this room is dying. The question is sooner or later. So the notion that we are talking about a segment or a sub-segment of the population who have now reached the point of some political clout and therefore can be co-opted so we can use that political clout, I say "Great," I'm delighted to become part of the larger society, but I think we have to have some equity as part of that larger society. And I don't think that in this democracy, where we do talk about coalitions, the way to get what we need is to immediately surrender and say that coalitions will do it all for us.

So what I am opting for is a very parochial orientation. I think the aging should be ready to make a deal with the rest of society. If the votes of the aged are going to count, and there are going to be many, many more of them, I think that that political clout has got to count for much more than it has in the past. I think we have seen in this marvelous democracy the power of the body politics, even in the sense where public opinion finally unseated a President. When we have the same kind of public opinion about the outrageous situation vis-a-vis aging in the United States, then I think we are ready to join wholly a larger society.

Let me make my last point, and I notice you are not clapping any more. (Laughter and applause) The last point is that we are talking about the aging as if we knew what we were talking about, and the sad truth is that we don't. This is one of the problems that we have to deal with. I'm sitting here being cross-examined as I keep trying to educate the attorney for the school district, as I have been trying to educate for twenty years in this field, what we know is a mythology. No one knows what aging is all about. You heard Ollie say what we said before. What makes sixty-five magic? Why not seventy? Why not sixty-four? Why not eight-three? How long will it be before we all reach a hundred? The notion of sixty-five, the notion that we can develop a n anchor point and the absurdity that we know something different about the sixty-five-year-old that we don't know about the sixty-four-year-old, that's what we have to break up. What we have to say is, "You know Mr. Harrington, you know the world, you know Congresswoman Schroeder. Look at the aged. They are us." Thank you. (Applause)

MODERATOR SCHROEDER: Dr. Cohen, you get to make the finishing touch.

DR. EUGENE COHEN, Chief of the Center for Studies of the Mental Health of the Aged, National Institute of Mental Health: Thank you.

Carl mentioned the problem of following the tour de force. I not only have to follow the same tour de force he did, but also Dr. Eisdorfer.

I am going to comment on three areas that Mr. Harrington touched on. Some of them are directly related and others are sort of associations to them. One relates to discussions of failures of programs; the second area is a look at the rich and the poor in some paradoxes; and the third area relates to full employment and retirement.

The first area, looking at programs that fail, to make it more in my area, to look at the health and particularly mental health arena, some interesting paradoxes emerge here. One can look at the millions and millions and, at times, billions of dollars perhaps that are put into this area and wonder what has happened with older people as to how successful these programs have been or how much of a failure. Well, the premise that I would go on is that the health program for older people has not been a program of failure but essentially one that has not been tried. With all the money and the different components that have gone into the health program for all the people in this country, we have essentially built a makeshift automobile, but we really haven't added the steering wheel or the tires. But from that perspective, we are really very close to getting it rolling. I think the best way to illustrate the paradox that I'm getting at is the dichotomy between services and the delivery of services. We have a multitude of services that are available to all groups within our society. We have a multitude of services available for older people. We have a wide range of knowledge which is available that has application in the health field for young and old alike. But one of the major problems of older people has been our failure to adequately deliver these services and the knowledge that we have. To a large extent, ever since the mythical journey of Ponce de Leon in 1512 to the Fountain of Youth, we have been very much on that same detour looking for very magical solutions and, at the same time, missing the immediate opportunities that we have to make use of very real and useful knowledge.

I will give you just an example from my personal experience. Apart from my work at the National Institute of Mental Health, I have also managed to hang onto a clinical involvement at a HUD building for older people. Six years ago, I looked at the mental health data that showed the poor utilization of older people by older people of mental health services. Most of the data at that time and still now reflect that the over sixty-five comprised more than 10% of the population with yet a greater prevalence of mental problems, and indeed one-fourth of the suicides in this country were the over age sixty-five group. We find that at mental clinics, public or private, fewer than 3% of those served were over age sixty-five. Now, if one looked at the amount of time, it probably would be dramatically under 1%. lqNow, people have looked at these data and have raised three different questions about them. Some have asked, "Does this reflect that older people have no real problems in this area?" The second question is, "Do they want help for these problems?" And the third question is, "Can you do anything about it anyway?"

Once I started delivering services at this HUD building, within the first year out of the population of more than three hundred people, almost sixty people had made use of the services that I had to offer, either indirectly through consultation or directly through services. Prior to my injury, almost none of these people had made use of traditional services on location. The issue that was very dramatically illustrated was that what we are talking about here was not so much a state of knowledge in certain areas, but the delivery of knowledge, the role of accessibility. And indeed with so many of these programs that we have now, we really haven't, in a very studious and diligent way, addressed the basic issues of delivering these services. Indeed one can look at Medicare that Mr. Harrington mentioned, and in the mental health arena it is very much skewed to the hospitalized. There is very little coverage on an outpatient basis. In that sense, it's a very regressive structure for an insurance.

As far as the business of the complexity of health problems for old people, there is very little opportunity to find this source to have a comprehensive evaluation or assessment, and without that starting point, the basic evaluation or opportunities for assessments, the proper disposition that would narrowly follow obviously cannot take place in such a circumstance.

Let me move on in this regard and talk about a paradox that comes up if we want to look at it from the money perspective or from the people perspective in terms of the rich and poor. I would say that the cause of this problem, in terms of delivery of services. that both the rich and the poor in the older population have been in trouble. This business of accessibility has been further complicated by the fact that there has been a whole range of myths, stereotypes of misinformation, that have affected (a) the recognition of problems by older people themselves, (b) the recognition by significant others, such as family members, and (c) even the helping professions have often very much overlooked the treatable problems. Involved here in any way is the confusion between what represents normal aging and what represents disease. In effect, what I'm saying is that much, in fact, that is disease or treatable illness or problems that can be approached has been dismissed as normal aging, and the myths, stereotypes of misinformation, at work here very often not only apply to the poor among older people, but to the rich as well.

Two other variants here that come into play are factors that I will refer to as detrimental action and detrimental inaction. From an historical perspective, we can look at somebody like George Washington who had the best medical care of his time. A part of that care involved bloodletting. I would say that is an example of detrimental action. We can see with many older people today, despite their having funds or potential access to services, too often what may happen is the lack of opportunity to have access to a structure that will do an effective and comprehensive evaluation to really determine the correct problem, because if that correct problem is not diagnosed or appropriately assessed, then that greatly increases the chance for a detrimental action.

The other component, detrimental inaction, relates very much to this business of very poor accessibility of services and the deficiencies in terms of the delivery of services to older people.

The third area that I would like to discuss is the business of employment and retirement. I think what has already been touched upon here today has been a confusion of just what the problems are that we are looking at in this capacity. In one sense, we are examining the psychosocial situation of older people around retirement. What does retirement mean in terms of its effects, good or bad, on older people, which people will do well with retirement, which ones will do poorly, etc.? But, at the same time, the motivation for retirement is at a very different level. It's the economic issue, the making jobs for others. And so unless we are looking at those two components at the same time — the basic economic situation, the business for jobs for the young, the business for jobs for all — and, at the same time, looking at the effect of work, the implications of retirement on the basic psychosocial well-being of all people, unless we look at these two areas together, we will continue to stumble along in an effective approach to that problem mainly because we are looking at it from two different perspectives.

So I think that essentially the main point that I am making is that I would agree with the point that has been made, that despite the gains that have gone on for older people in the past couple of decades in terms of funding, I would agree with Carl Eisdorfer that the situation is still extremely serious. But I would also say that we have from an immediate perspective a tremendous opportunity to have an impact on the problems, because we have really failed to implement an effective program of service delivery for older people. (Applause)

MODERATOR SCHROEDER: Thank you very much. We are really right on schedule and you have almost a whole hour to come back. But we are first going to let Michael answer the panelists for about three minutes, and then there is a microphone out here and we will let you take us all on.

MR HARRINGTON: First of all, I can't answer Ollie, because I agree.

There is just a couple of points I wanted to make. There is one to Dr. Cohen on the utilization problem. I think it's a clinical problem and not just of the aging. One of the fascinating things that a Brookings study came up with about two years ago is that the utilization of Medicare and Medicaid is profoundly related to social class. The reason is that more well-off people on Medicare — not on Medicaid obviously — have access to doctors, know where doctors are or live near doctors. I think there is a real problem. You can't just put in the law a theoretical right to medical care. You've got to deal with the practical problems, that sort of thing. This is again the problems of not just the aging; it's the general sociological problem of the society.

Secondly, to Dr. Flemming, I agree with about everything he said, but just let me complicate our lives a bit. I want to complicate it in this way. There is a very brilliant book by Lester Thurow. Lester Thurow is a brilliant young economist at M.I.T. He was an advisor to Jimmy Carter during the campaign, but unfortunately is not an advisor to him now. Thurow wrote a book called, "On Generating Inequality," and he's talking about why employers hire and don't hire people. He points out that when employers look at what he calls background characteristics, one of the reasons that employers don't want to hire women is that employers have a theory that women are going to get married, they're going to have kids, they're going to break their work cycle. They don't want to invest in them: it's better to invest in a man. Obviously, with older people you don't want to bring somebody in when you are going to have relatively high fringe benefits, the pension costs, etc.

What I am saying is that it is complicated. I think there is a profound resistance in the private sector to what we are both for, which is providing employment opportunities. Therefore, in this area, as in many others, I think that public service employment is an absolutely necessary tool in this society to achieve full employment. I think there we have a much easier assignment dealing with the aged and we can sort of write it into the law because it is a public form of employment.

Finally, just a couple of comments on Dr. Eisdorfer's comments. One, I completely agree that we can't have a happy, wonderful, welfare state for everybody in the United States and forget the 94% of the people in the world.

Let me share with you a very funny conversation I had this summer with Julius Nyerere, President of Tanzania, who told me that when he was on a state visit to West Germany he said to Helmut Schmidt, the Chancellor, "Mr. Schmidt, the Americans have 6% of the people and 40% of the resources. The Russians want to catch up with and outstrip the Americans and the Common Market wants to catch up and outstrip the Americans. Mr. Schmidt, when the Russians, the Common Market and the Americans have shared 120% of the resources of the world, what's left for us?" So in all of this, I think that is an enormous dimension that we have to keep in mind. All I would add is that only full employment in America is going to begin to do justice to the Third World. One of the main Third World demands is that we allow more manufactured products from the Third World into this country. We won't do it with high unemployment.

Finally, to get to the coalition question, which I think is a very tough question, let me try to deal with it. I don't believe in saying that the aging should be in coalition. I don't think it's easy; I don't think it is unproblematic; and I don't think any group in a coalition should disband its own special army, so to speak. I could suggest that it go in there to get as much for itself as it can, but to understand that alone it can't get these things we are talking about here today — that the aging alone cannot get the Social Security, the medical care, the employment.

Now, related to that, will the American unions today come out against mandatory retirement? My guess is that most of them would not. The reason is not that they are evil people. I think, on the whole, they are some of the best people in the country. The reason is that unemployment is so high. But if you had a full employment economy, the aging could get to the unions and say, "Look, you want a full employment economy: we want better treatment on the question of retirement. If we go in together, you get our support for the full employment economy and we get your support under those conditions for our demands on work for the aging." I think it's that kind of bargaining and quid pro quo that has to go on. But I think it has to be together.

Now, the last point on which I thought somebody raised an excellent question. What is work? Is work only paid work? On the retirement question, so many people in this society want to get out of a job because they don't like it. It is certainly the attitude of most automobile workers, and I suspect an awful lot of blue-collar workers, that you can't humanize the job. The job is just inhuman. The way to humanize it is to get out of it. What I think we have to think about, and I know you have thought about this, is forms of work that we don't now call work. I think that's very important. In this society, we have grown up on the protestant ethic, and I use the term sociologically, not theologically, that your worth in the eyes of your fellow men and women and in the eyes of God is established by how much dirty, miserable, menial, onerous work you do. The unhappier you are, the more virtuous you are. And I think that we may be at a stage in our technological society where we might actually have to plan some happy work for people, particularly if we are going to deal with the problem of work for the aging. (Applause)

MODERATOR SCHROEDER: Thank you. I think probably the easiest thing to do is to have people come and line up in front of that microphone which is right there in the center aisle, if that's all right. In that way, we won't have to be waving flags. You may address the question to any one of the panel members, however you would like to do it.

CURRENT PRACTICES IN GERIATRIC HEALTH SERVICES

EXPANDING ROLES OF GERONTOLOGICAL NURSES

Coordinator: Jacqueline Heppler, R.N., M.S., Asst. Prof., Geriatric Nurse Practitioner Program, Univ. of Colorado School of Nursing Cont. Educ. Program, Denver.

Resource Persons: Ruth Fleshman, R.N., M.S., Community Nurse Practitioner, Nursing Dynamics Corp., Mill VAlley, CA; Audrey Ostberg, R.N., M.P.H., Adult Health Nursing Consultant, Colorado Dept. of Health, Denver; Erika Saak, R.N., G.N.P., Geriatric Nurse Practitioner, St. Luke's Senior Citizen Health Ctr., Denver; Eleanor Turnbull, R.N., M.S., Senior Instructor, Univ. of Colorado School of Nursing, Denver.

Recorder: Thomas C. Timmreck, Ph.D., Asst. Prof. of Community Health and Health Education, Texas Tech Univ., Lubbock.

OPENING

By Jacqueline Heppler.

The Geriatric Nurse Practitioner (GNP) Program is for the practical person in long term care. Nurses in the past have not been creative in long term care. Undergraduate programs are inadequate in Geriatrics. The elderly patient/person is not viewed in the total person perspective. Constructive intervention to help programs and service, such as political activity are lacking. Nurses have relinquished roles in caring for geriatric patients. Home Health Agencies have not been strengthened. Nurses need to acquire personal assessment skills to work in such a system of care.

CREATIVE ROLES FOR NURSES IN HEALTH CARE

Four phases of Health Care Delivery:

1) Enrollment-Health Screening
2) Health Maintenance-Patient Education
3) Long Term Management of Chronic Disease
4) Sick Care-Patient and Disease Management-Physical Assessment

Course Content:

1) Patient Education Techniques
2) History Taking
3) Disease Management
4) Role and Attitude Change Towards Advocacy for Elderly

The GNP Program now trains students on the semester system with 3 days a week in-class training. To get accepted to the University of Colorado GNP Program, the person must be employed in Geriatric related work and have a preceptor to train under.

Age Related Differences:

1) Normal Aging Process
2) Societal Attitudes Toward Dying
3) Theories of Aging
4) Behavior Changes as a result of multiple losses including sensory defects.

Developmental Tasks of Aging:

1) Reminiscence and Life Review
2) Retirement
3) Widowhood
4) Relocation
5) Change in Sexuality
6) Preparation for Death

Community Resources for Other Psycho-Social and Economical Problems

Federal and State Regulation Affecting Nursing and Aged

Modalities of Interventions in Remotivation

GNP UTILIZATION:

1) Nursing Homes
2) Out-Patient Departments and Clinics
3) Private Practice Physicians
4) Public Health Nurses

Projected Use of the GNP:

1) Day Care Centers-Night Care, Respite Care
2) Mobile Helath Screening-Rural Area Health Screening
3) Rehabilitation Facilities
4) Hospice

GERIATRIC CONTENT IN UNDERGRADUATE PROGRAM

by Eleanor Turnbull.

Geriatrics has been overlooked in educational programs and in nursing students education. Programs are mostly aimed at O.B. and Pediatrics.

Many studies indicate that working preference toward the elderly were low. Little excitement was shown to work with the elderly. Other studies showed attitudes can be changed remarkably towards older persons and working with them.

University of Colorado Medical School focuses the curriculum on wellness and needs. The six week practical experience now at senior level would be better if it were at both the freshman and senior levels. The training and understanding has been found helpful in all areas of nursing i.e., medical/surgery. Wellness experiences are stressed, i.e., Retirement Villages, Meals-on-Wheels.

PRACTICING GNP:

By Erika Saak.

St. Lukes Hospital is near midtown Denver near an older area and an elderly high rise apartment. Twenty thousand elderly live within a 2 mile radius. The main goal is comprehensive health to the over 65 persons, plus keeping the elderly patients fit and well for independent living. Downtown hotel tenants are also served and aided in social problems. Patient education is conducted. The hospital also provides clinical experience for GNP's. The facility is also an extended care and medical screening and testing center. Outreach services are provided. The role of the GNP is viewed as a primary care provider who also considers social problems, and one that does counseling, teaching and helps in a warm caring manner. A team approach is used using an unhurried, warm relationship building approach that shows that you care.

LIFE TIME HEALTH MEASURES TO DEVELOP INDEPENDENT LIVING

by Audrey Ostberg.

The concept of the Well Oldsters Clinic needs to be advanced. They can be run cheaper than many other similar programs. The public health nurses are mainly a teacher and counselor and they incorporate secondary prevention. Detection of degenerative and chronic diseases. With the use of the public health nurse, the older person can be maintained in their home and avoid institutionalization. Lack of knowing what to do with the older person has been one of the biggest problems i.e., blood pressure screening, socialization, talking, physical assessment.

THE COMMUNITY HEALTH NURSE PRACTITIONER

By Ruth Fleshman.

The role is a "gerontology" nurse not a geriatric nurse. Disassociation is made from the illness model. The nurse deals with the 95% of the well population in levels of functioning towards optimum levels of health i.e., blood pressure screening in the local drug store in rural areas, or at recreational centers. Home screening is also done. Change in a non-negative sense is experienced with personal confidence and responsibility being stressed.

Systems screening assessment is reviewed and control is attempted where necessary.

ISSUES IN DENTAL SERVICES FOR THE ELDERLY

Coordinators: William A. Read, Ph.D., Asst. Prof., School of Dentistry, Univ. of Washington, Seattle & Charles C. Swoope, D.D.S, M.S.D., Prof. of Prosthodontics, School of Dentistry, Univ. of Washington, Seattle.

Resource Persons: James Bennett, D.D.S., Prof., School of Dentistry, Univ. of Oregon, Health Science Center, Portland; Neville Doherty, Ph.D., Prof., Univ. of Connecticut Medical Ctr., Farmington; Shalom Pearlman, D.D.S., Prof., School of Dentistry, Univ. of Colorado, Denver; Richard O. Shaver, D.M.D., Clinical Instructor, School of Dentistry, Univ. of Colorado, Denver.

Recorder: Joe Ann Hyer, RSVP Director, Marion County, Oregon.

In introducing the subject, Dr. Read explained that this is the first time that a panel has been held at a W.G.S. meeting on the subject of Dentistry. In studying dentists, it is important to know their knowledge and attitudes and how it effects dental care.

In the State of Washington, there is a good Medicaid program (for those earning under $202.00 per month). Coupons are issued for dental care, allowing $400 for dentures, paradontical care, etc. It has been hard to find dentists that will accept the coupons and then it is difficult to also find transportation for those needing it. For those that have incomes over $202.00, only community programs are available. One community has a one year waiting list. Washington, D.C. indicates there may be national funding for the youth, under 15 years of age, but nothing for the elderly for a long time to come.

Fred Leviton reported that his agency refers elderly persons to Dental School for treatment. There is a proposal, Handicapped Program, where dental resources have not been utilized wholly. The Dentists are not coordinated. Care to the elderly is crisis-treated instead of preventative-oriented. Approximately 40% of nursing care residents or homebound persons need dental care. There has been a lack of understanding by Nursing Home Administrators as well as a lack of portable equipment. The mobile unit helps but persons cannot always get to the van. Portable equipment is being designed to take to the bedside of a patient. Usually no x-rays are available so this could be a major problem. There is a definite need for good high quality portable equipment for providing dental care.

The reasons for lack of care in Nursing Homes:

1. No central agency to provide coordination.
2. No portable equipment available of high quality.
3. No means of transporting and not all dentists can own equipment.
4. No one acts as a liaison for Nursing Homes, Dental Professionals and the Community.

Some arrangements are made for care through the Dental Schools with partial reimbursement. The lab work is done in the Van itself by a Dental Technician. The whole treatment could be completed in fewer visits than in a dentist's office under normal conditions. This plan would take approximately three months to get started after the funding is approved.

Dr. Bennett talked about the "Multistate and Variable Team Model for Geriatric Dentistry." The purpose of the model dental program is to provide dental care to the disadvantaged elderly in a variety of community contexts; and to develop and implement a service system with as "low barrier" characteristics as possible. The dental group must consist of a minimum of four people, or ideally the minimum would be eight. The dentist and hygienist should be part-time staff to the professional.

This should be a mutual program contracted with the nursing home to provide dental care. The patients participate on a sliding scale fee basis. The dental team staffing would include: bookkeeper, dental assistant, dental hygienist, dentist, logistic technician. The total staff costs for 40 hours per week is estimated at $2,000.

At this point, a chart was shown on the projector that gave estimated breakdowns using the various staff people in given situations at so much per hour. These costs included the base costs, overhead, materials, equipment in various settings such as a private home, field clinic, and a nursing home.

Dr. Bennett stated that the contracts must describe what a dental group will provide for the agency. Everything must be documented with charge slips and records furnished to the nursing home. The person (family member, etc.) that is legally responsible for the patient, must decide what happens to the patient. The dentist must be sure to prescribe the type of toothbrushes and dental floss, etc. that must be used in dental care of the patient. The nursing home agrees to specific things to help the dentist. In negotiating the contract, it must stipulate the amount of time and costs and maximum hours per month. It is important that all of this is understood by both parties.

Outline care to be provided would be: Phase 1 - emergency care first to include extractions and temporary fillings; Phase 2 - to include cleaning, fluoriding and preventative care, and Phase 3 - to include partials, bridges and other permanent care. All of the fee schedules are set by Medicare.

Dr. Daugherty was the next speaker. He talked on Dental Care for the elderly and the "Triage" project. This is a model health care system for the elderly including assessment of needs, organization, delivery and financing. The problems are defined, evaluated and services provided. A nurse clinician assesses patient needs - physical, mental, dental - including housing. Then the services are ordered.

These services include: Home health aides, chore service, companionship services, homemaker services, etc. In Connecticut, with a population of 100,000 that includes industrial and rural areas, 20% are elderly and of those, 20% are below poverty level. Persons eligible for Medicare are eligible for Triage. Under this program, there is no charge to any clients. Medicare is waived and dental care added. The object is to maintain people in their own homes.

Dr. Daugherty stated that one day the dentists are complaining that too many dentists are graduating from Dental School and they themselves are not busy. The next day the dentists are refusing to see Medicare patients.

The Triage Project model period is three years (1980). It took three years to get underway. The objective is to screen 2,000 patients. Nutrition and eating is a real problem with the elderly. The Triage Project started at the end of 1976 for screening and evaluation of patients.

The DO HAVE list includes:

Assessment of dental needs; time since last visit, need as expressed by client, and nurse clinician assessment of needs.

The data from these items are:

Fifty percent had not seen a dentist in five years.

Clients claimed one or two problems such as bleeding gums, painful teeth and jaws, denture needs, poor fitting dentures. Some said there was no problem at all.

Twenty-one to thirty percent stated poor fitting dentures and problems chewing.

The nurses evaluation of need: sixty-three to sixty-seven percent had no needs. The largest need was prosthodontic care. The nurse clinicians recorded no need if clients refused relining of dentures. The average bill per client is $234.

Since this is a very new program, there is no good measurement to report. By this time next year, there should be a great deal to report.

The greatest thing about the project is that it provides total care. Nurse clinicians are the primary figure. Dentists and dental assistants are employees of the program. Patients pay nothing. Transportation costs are covered in the project and all work is done in private dental offices. Referrals are made by anyone that knows of someone needing the service.

Part of the role of the nurse clinician team is patient education. Prevention and client education are very important. Triage Project is designed with nurse clinicians providing continuous training at nursing homes and central sites, neighborhoods, etc. in dental care and oral care.

Dr. Pearlman talked about dental care in a nursing home or with a control population. He stated that if no dental services are available, there is less reinforcement of oral hygiene as a personal value, no socio-economic values, no demand, no dentists to practice—a vicious circle. Economic access and convenience is important. Extending dental services to the elderly is necessary. Dr. Pearlman presented a chart that depicted the circle for oral care in a control population.

Dentists correct pathology — dental hygienists treat problems and train patients to stay well — oral health aides (not developed yet) should sustain the maintenance of wellness — contact and observe daily or frequently — detect and report slippage of home care techniques or suspicions of abnormality. The hygienist confirms appointments and assesses wellness — dentists examine and diagnose — dentists plan course of treatment — (back to) Dentists corrects pathology. It is necessary to build up a registry of dentists. In that registry, we can get a dentist to work on the patient if the patient does not have a dentist. Hygiene care is necessary; must get dentist authorization of specific care.

Dr. Pearlman reported that the Seroptomists in Denver raised money for dental care. Some dentists volunteer their time and money was raised for lab fees. There is a great need to develop voluntarism in dental care. Not nearly used enough today. In the Denver area, it is estimated that thirty to forty percent of the patients will have funds to pay for their own care if the fees are reasonable. There is a program planned where "Oral Health Aides" will be trained by some dentists (active in working with elderly and handicapped) and hygienists with some help from the dental school. Senate Bill 18 in Colorado is to provide dentures, denture repair and oral surgery ($350.00 maximum) for each patient. Dr. Bennett stated that he felt people should be allowed to pay for their services. Many of the elderly are not on welfare and to have means for paying for care. He touched on a bill that is presently in legislature in Oregon to license Denturists.

Dr. Daugherty stated that he believes that health care should be available at no cost to the person. A person should be able to pay if they wish to but have the alternatives available.

MENTAL HEALTH CARE: SPECIFIC ASPECTS OF CARING

Coordinator: Irene Mortenson Burnside, R.N., M.S., Author/Lecturer, Monte Sereno, CA.

Resource Person: Helen Elene Monea, R.N., M.S., Author/Consultant, San Francisco, CA.

Recorder: Florence Phillips, Professor of Psychology, Texas Tech University, Lubbock.

The song "Hello in There", by Bette Midler, structured the Mental Health Care workshop. Participants said "Hello in There" to each other, to the mentally impaired elderly, and to themselves.

Irene Burnside and Helen Monea gave symbolic introductions of themselves, then each participant said "Hello in There" to another participant through a symbolic introduction. After selecting an item from purse or pocket, each person told how the object was representative of him or her as an individual. Irene Burnside said "Hello in There" to the mentally impaired elderly through a discussion of reality testing, the use of touch, and empathy. Dishonesty is a facet of reality testing which should be given serious consideration. This behavior on the part of relatives, as well as professionals, leads to mistrust and fear in the aged. Integrity and trust-building with the most mentally-impaired individuals should characterize professional relationships with the aged.

The effectiveness of the therapy of touch can be maximized through a quick assessment of the older person's life style, severity of sensory losses, pain, illness, and loss of significant others. Assessment of these conditions affects how and where and how long to touch an older person. Professionals may process much information in a short period of time. As a result of previous positive experiences with touching the elderly, they are willing to take risks. They will be less afraid of being rebuffed or rejected, and will reach out and touch. Emphasis should be placed on helping young students to increase their sensitivity to the needs of the elderly and to develop their feeling of empathy when working with the older person.This is especially important if they have been strongly influenced by society's negative view of aging.

Helen Monea concluded the workshop by asking the participants to say "Hello in There" to themselves. She directed an experiential exercise which was designed to help them consider how they did or did not take care of themselves especially during stressful times with the regressed or mentally ill elderly.

A slide presentation included the following: a man with no hands, a suicidal man refusing coffee, a regressed patient holding a doll, a drugged old woman, a hallucinating man, and a dead client. After a body relaxing exercise, participants were instructed to take a deep breath and to be aware of their reactions to one person or situation in the slide presentation. They were asked, "What is the feeling you have? How can you take care of that feeling?" Workshop members were asked to write a description of their feelings and possible ways of coping with these feelings. It was suggested that each participant share his or her feeling with the person they had met at the beginning of the session. After another relaxation exercise, the workshop was concluded with the statement, "Go take care of yourself."

KEEPING IN TOUCH WITH OUR AGED SELF: THE INCORPORATION OF REALITY STRATEGIES INTO OUR ENVIRONMENT

Coordinator: Tika Beard, Consultant in Geriatric Recreation and Instructor, De Anza College, Cupertino, CA.

Resource Persons: Priscilla Ebersole, R.N., M.S., Asst. Prof., Dept. of Nursing, San Francisco State Univ., CA; Sharon Henry, therapeutic Recreation Consultant, San Jose, CA; Marie MacCord, R.M.T., Instructor, Los Altos/Mt. View Adult Education, Menlo Park, CA; Rudeen Monte, Consultant, Electric Sunrise, San Francisco, CA.

Recorder: Shirley Misty Martinson, Project Director, Hot Springs County Sr. Citizens Ctr., Thermopolis, WY.

How does it really feel to be old and to be taken care of? Why do the elderly react so "strange and violent" to their handicaps? What are the developmental tasks that the elderly must accomplish and how can service providers assist in this accomplishment? These were questions we faced as participants in this workshop and as we became, for a few hours, the elderly residents of a long term care facility.

It is amazing how quickly the emotions run from hostility to anger to passivity and back when I became handicapped by blacked-out glasses representing tunnel vision glaucoma or was given a hearing loss with earplugs or had to sit and watch others eat cookies when I was on a restricted diet. All these feelings—even when I knew it was only to last 20 minutes! How much greater then would the reaction be if a person had a permanent disability?

How frustrating to be unable to perform even the simplest physical activity for myself. But some things help. Finding out who I am now and realizing that I am still a person of worth and significance and relaxing in that knowledge—that's a goal to seek! It helped to see and acknowledge myself physically. Television became a real and important part of my life in the long term care facility. One sweet lady talked to me when I was on television. She asked me about dinner and my name and where I lived. I saw myself on the TV screen and I knew it was me. Those questions helped me to place myself in my current environment. Someone else said a mirror can work the same as television.

Another lady let me tell about things I'd mastered in the past—problems I overcame—things that were worthwhile and things that made me a special person. She said reminiscence is important because in this life I can review, process, bring up conflicts and resolve them for myself and can then let go of them. This releases my energy for other uses. Being in a group helped a lot. She suggested that I might like to define a legacy to leave to others—maybe a family history, crafts collection, recipes, wisdom I've distilled through the years. It sounds like a good idea. I've got a lot to share.

Yes, it was a good day at the nursing home. . . it's not such a bad place to be, because I'm important and they really care.

INTEGRATION OF SOCIAL WORK AND HEALTH SERVICES

Coordinator: Barbara Caley, Dir. of Social Services, Sr. Citizens Health Ctr., St. Luke's Hospital, Denver, CO.

Resource Persons: Jane Collins, Dir. of Social Services, Denver General Hospital, CO; Louise P. Lintz, Medical Social Service Worker, Weber County Dept. on Aging, Ogden, UT; Melanie Livengood, M.S.W., Denver, CO; Corrinne C. Williams, Consultant for Congregate Care, Dept. of Human Resources, Salem, OR.

Paper Presentation: "Hospital Social Work" by Jane Collins.

In discussing hospital social work, I will focus on three mains areas:

1. The team approach and hospital social work services.
2. Responsible record-keeping.
3. Ways of developing a power base and gaining access to authority.

It is important to look at the health needs of hospitalized older persons in a comprehensive manner. Each member of the health team has a special contribution to after-care. This comprehensive planning seems extremely obvious, but is something which frequently does not take place. The word "team," in my experience in the medical sections of a health-care setting, is often a myth and a fiction. Frequently, in fact, there is no team functioning as such. Perhaps it is not possible to have structured multi-disciplinary teams in many hospitals. What is an alternative?

One possibility is the formation of informal teams for each patient needing planning services. In other words, patient needs differ; consequently, those disciplines which should be represented in planning for a patient will vary from one patient to another. In one situation, speech therapy for a period of time may be an important factor and it may be important to involve a speech therapist from the hospital or one from an outside agency who will be actually doing the follow-up treatment with the patient.

Often the social worker is the person who is going to know most about the resources which will be available to provide for the needs of the older person being discharged from the hospital. The social worker, therefore, can function as a coordinator between all the disciplines which are involved with the hospital care of the patient. The social worker can appropriately be aggressive in determining that all the patient needs in the after-care situation he is going to will have been evaluated before the patient's discharge and that plans have been made to meet identified needs of the patient. Areas to evaluate include how the patient is coping with the psychological aspects of his illness and how he is feeling about the changes which he may have to make as a result of the illness.

Because of the pressures of caring for patients and the demands of actually giving the physical care and necessary treatments to patients, physicians and nurses often are not able to spend time identifying and working with the psychological concerns which are keeping a patient from cooperating in planning. Because social workers do not have the responsibility for the actual physical care of the patient, they can be psychologically open to allowing a patient to express his fears of fantasies.

Patients may respond in ways which are not indicative of their true feelings. It is important for social workers to be aware of appropriate patient responses to particular situations. When patients are denying that they will have to face problems, this is an indication for early social-work intervention. It can be very difficult to help older patients express feelings which they may find frightening or unacceptable. Social workers in hospitals are not unfamiliar with those older persons who deny that they will be unable to care for themselves as they have in the past. Simply lecturing them about the fact that they are no longer able to take care of themselves and must think of something else as far as their living situation is concerned is apt to only increase their fear and resistance to looking at the alternatives.

Though we all see many hospitalized patients who are depressed to a greater or lesser degree, the older person often may not respond positively to an offer of conventional psycho-therapy. It is possible, however, to help the older person examine his depressed feelings. Sometimes it can be possible to help an aging person express his feelings of depression by focusing on the concrete problem which he is facing and then helping him express the negative feelings which relate to that.

Probably the fears that result from loss of function, and consequent inability to continue in the same living situation or with the same activities, is the example which occurs most frequently. If an older person can be allowed to express his despair at what has happened, it then may be possible to help him examine what remains in terms of his ability to do for himself and his ability to carry on those activities which have been pleasurable for him.

Social workers should have a special awareness of the variety of living arrangements and activities which can be appropriate and meaningful to older people. We thus become the discipline which logically should carry basic responsibility for discharge and aftercare planning. This can help insure that those activities will be developed which are possible for a patient to the limit of his abilities.

It is important that a care plan not be made at the time of hospitalization and then agencies involved in follow-up drop their parts of the plan. If social workers have caseloads of any size, it is important to develop a monitoring system either within the worker's caseload, or within the social work department. This can insure that some months later there will not be an accidental discovery of the fact that an essential component of the patient's care plan was never carried out. An example of this is that of an elderly gentleman who has been quite active his entire life, but who, because of severe lung disease, is going to have to be considerably more restricted in his activities. He has responded with great anger to the fact that he no longer can fish or make furniture which he had enjoyed doing in the past. Through talking with a social worker, he has come to see that he would like to continue to work with his hands. Because there is a senior services center not too far from where he is living, the worker has made arrangements for him to join in some of the non-strenuous woodworking activities at that agency. Although his physical activities have been quite drastically curtailed, he has been helped by both the physical therapist and occupational therapist to learn how some of his activities in his small apartment can be part of his daily exercise plan. These activities can be carried out with the degree of vigor which he is able to sustain, and can help him keep as active as possible. He also will go to a rehabilitation center on a weekly basis so that his exercise program can be monitored and kept at a level which is appropriate for him with his physical problems. The social worker has arranged that a senior companion will visit him weekly for a social contact. If any of the components of the after-care plan are not carried out, it may limit this patient's potential to live independently and actively within his limitations.

Because social workers are often aware of the various support systems existing in the community, it can be possible, with some ingenuity, to intervene in ways which will greatly relieve the anxiety of hospitalized older persons. I am thinking of the example of the number of older people, who are hospitalized and who have cherished dogs or cats at home for whom they cannot afford to pay boarding. Yet these animals are both valued and valuable companions to them. We have been able to work out arrangements with the dog pound, whereby those animals will be boarded without charge, until the older people can resume care for the dog or cat. This is a very small thing, in terms of all the considerations which must be kept in mind for hospitalized persons. It can, however, be influential in helping the patient accept and adjust better to hospitalization. I use this example because the arrangement was an outgrowth of the concern social workers had for elderly persons who were unable to provide care for their pets.

There are other supports which can be worked out to help an older person give up as little as possible of his life, even though he may have to be hospitalized for a period of time.

As we think about getting pertinent information as to our activities on behalf of an older person into the medical chart, it is well to keep in mind that, at this time, medical charts are used for more than having information available to all concerned about the patient's status from a comprehensive aspect and the planning and treatment for his condition (this includes social work and other types of treatment). Another use is that under PSRO regulations, charts may be subject to audits of one kind or another. The experience in many hospitals regarding social work recording is that initial assessment recorded in the chart usually tends to be quite adequate. It is as the working relationship with the patient progresses, and ongoing social work treatment is taking place, that information becomes recorded on a much less organized and consistent basis. The recording of care plans and outcome of social work treatment often is not available in the chart, or if there, is so briefly recorded as not to be helpful.

Depending upon the recording system of the particular hospital where the social worker is functioning, it is necessary to develop those standards which are appropriate for the social work recording. If charts are going to be used for auditing or Medical Care Evaluation study purposes, there needs to be uniformity in the structure of the recording, and in the expectations of the kind of information which should be recorded. Basically, this is not that much different from the old problem statement, assessment, treatment, disposition format, which has been used for many years.

Perhaps what has changed is that we have found that there needs to be more awareness of those areas which must be recorded consistently. For example, if a patient has many problems but he and the worker wish to work on only one of them, this should be clearly indicated in the recording. There should be regular charting as to the progress, or lack thereof, that is being made on those problems which are being addressed by both patient and social worker. It has been found to be more helpful, both to patients and social workers, to initially focus on those problems where there is some evidence that either the patient can make changes himself or, with the help of the social worker, changes can be made in the environment or other aspects of the patient's living situation.

There are two different ways of approaching recording, and then auditing the recording which has taken place. The first is to identify those components of recording which must always be present on all cases. The second is to set standards of social work recording for specific disease entities. Both through chart review or supervisory conferences it is possible to determine how well the recording is meeting the standards of the social work department.

Under PSRO legislation, acute health care facilities, at this time, are required to have a certain number of Medical Care Evaluation studies complete each year. The number varies from state to state, depending upon the PSRO structure within the state. The PSRO guidelines require that all professional departments within a hospital must develop not only their own auditing process. These studies may be done by department, by several departments looking at an agency-wide problem, or by several hospitals joining together to study an issue which is of mutual concern.

For our purposes, it is probably most helpful to consider the first two types of Medical Care Evaluation studies. Social work departments may develop their own or they may combine with other departments when a situation which is occurring throughout the hospital or which affects more than one department in the hospital should be studied.

The Medical Care Evaluation studies are of particular importance in regard to older people because of the need to make certain that all components of a discharge plan have been carried out. Such studies may also provide a check on the continuity of care, particularly as it may relate to care in an outpatient clinic under the jurisdiction of the hospital. I have brought the schedules for a Medical Care Evaluation study which is being carried out for our department, and I will be glad to talk about this further during our discussion period.

I indicated at the beginning that all three sections of my talk are closely inter-related. I am sure that you have perceived how some of the ideas I have discussed up to this time have touched upon ways in which social workers can develop a power-base and therefore can have some significant input into decisions which are made within the administrative structure of the hospital.

It is important to identify those areas in which social workers have particular expertise and then determine what parts of our work we will use to demonstrate that competence. For instance, if in your hospital social work is the discipline which carries the major part of the responsibility for discharge planning, it may be possible to have the social work department designated as the professional department responsible for discharge planning. If this can take place, it means that administrative decisions concerning policies relating to length of stay in the hospital; the responsibility of the hospital, if any, for after-care; and working agreements or contracts for nursing home care can then involve appropriate members of the social work department.

It is important to attempt to insure that a member of the social work department is on the Medical Care Evaluation or Utilization Review committee. Although the PSRO structure, as we now know it could be changed in the future, along with other changes in the health care delivery system, it is not likely that there will be a diminution of the auditing procedures. This is not only because of the concern at giving good patient care, but also because all the auditing procedures are closely tied to attempting to put some cost controls on health care.

If a social worker is on one of the advisory committees of a regional or a state PSRO, it is important that that social worker, if a hospital-based person, give feedback to the administration about pertinent matters which are discussed at the advisory board meetings.

Social work supervision, which has been in an ambivalent position for years, being seen as necessary but also being in considerable disfavor, can be used to the advantage of the social work department in gaining respect and consequent access to the power base. Physicians have not had a comparable accountability structure. It seems that social workers are perhaps more accustomed and better able to adapt to the new accountability requirements than a discipline which has not traditionally had such an accountability structure. Traditional supervisory models may be used to determine that the individual workers are providing their patients with treatment goals appropriate to the level of the patients functional ability, and that they are paying attention to those areas which have been found by the department as being essential for good social work treatment. A peer review system can be developed through staff involvement with workers developing standards and reviewing each other's work. My own feeling is that supervisors should be left out of a peer review system, unless they are auditing work of their peers — that is of other supervisors. A system can be developed which allows for deficiencies uncovered on audits to be fed back in a way which can be positively used in the worker-supervisory relationship. Such a dual evaluation system means that the supervisor becomes responsible for the learning needs of the worker, and that the peer review system identifies those areas where more than one worker is demonstrating deficiencies, or identifies one worker who is falling down significatnly in certain areas. Inservice or as PSRO guidelines state, corrective action programs, may be developed which will upgrade the functioning level of all staff members who are shown to have similar kinds of deficiencies, either in their services to patients, or in their recording.

Although workers are often overburdened with large caseloads, and the heavy demands which working with this particular patient population can place upon them, it is possible to develop small studies which will document the value of social work services. For example, a study can show, from the standpoint of social worker involvement or non-involvement, or when there has been a delay in getting a referral to a social worker, the comparative lengths of time patients must remain in the hospital after they are ready for discharge. It is also possible in regard to patients who are rehospitalized shortly after their discharge, to make a rough determination as to how much that re-admission was affected by the fact that either a social worker was not involved, or the discharge plan was a hastily made one, and was not entirely appropriate to the patient's needs.

If social work intervention can demonstrate that the patient has improved in his utilization of health care, this information can be documented and presented to the administration of the hospital. These studies seem to be easiest to carry out at the out-patient level, where both over- and under-utilizing patients can be studied. Both groups of patients can be management problems and expensive to a hospital and it is possible to document savings which are made to the institution as a result of a change in patients' patterns of using health care.

Many hospitals are developing protocols to be used in the determination of when to terminate the use of life-sustaining procedures. Social workers should be involved in the development of hospital policies in this area and can make every effort to have one of their members on the committee or team which is responsible for working with the family and coming to a decision about stopping life-sustaining measures. Put very simply, I believe that by providing professionally competent and thorough social work, by policing ourselves, and by documenting our services so that they can be demonstrated to be a vital component of the hospital, we will be better able to help those elderly patients for whom we have both responsibliity and concern.

Paper Presentation: "Social Work in Long-Term Care" by Melanie Livengood, M.S.W.

Social work is a relatively new and ill-defined component of long-term care. Part of the problem, is such that it lies in the state of the profession itself. Social work is struggling to define itself and to achieve some measure of quality-control; licensure laws in many states grow directly out of this concern. We worry: is social work an art or a science? Do we have specific knowledge that is transferable to other practitioners? How do we complement, compete with, and stack up against such related disciplines as psychology, psychiatry, political science?

Social work in nursing homes is even more loosely defined. In Colorado, for instance, the only activity required of a social work "designee" in a long-term care facility is "the identification of medically-related social and emotional needs." The person designated to do social work in a nursing home may be, and most often is, wearing primarily some other hat—activities director, medical records clerk, admissions officer, nurses' aide. There are at present no state or federal regulations governing either number of hours spent performing social work functions or educational or experience requirements for the designee. Similarly, each facility is required to have a social work consultant, but there are no standards for number of hours spent in the facility and very few concerning themselves with the functions of a social work consultant.

Regulations are coming. Unfortunately, like social work licensure, they seem to focus on regulation of process rather than either content or, that most slippery of things, outcome. That is, it is far easier to create regulations about the number of hours a designee and/or a consultant must spend doing social work, or about the letters these persons must be able to put after their names, than it is to address the real issue of delivery of quality services to the residents. Personally, I find the current ill-defined state of the profession exhilarating. Since nobody knows what we are "supposed" to be doing, we can do anything we want to do.

We hear much talk about the medical model, and it is a real problem in long-term care. The medical model makes us think of our clients as patients, and we focus on their limitations, on the things they have lost, rather than on their strengths. The medical model is largely responsible for the institutional tone of most nursing homes; they are set up like hospitals and governed by regulations developed for use in hospital care. The medical model, with its necessary emphasis on protection and physical stability, tends to decrease the willingness of both staff and residents to take risks; this is, of course, an occupational hazard in any "helping" profession, but in a nursing home it is often most appropriate for the social worker to be the spokesperson for the right of the resident to take risks with his/her own life. The medical model ties us to physicians, whose word is law, who must be consulted about practically everything, and who seldom know their patients as whole and complex people; physicians are trained to save lives and get people better, and they have a hard time dealing with chronically ill or disabled people. Physicians tend to grumble about "this damn patients' bill of rights" because it can interfere with their medical treatment, and a dismaying number of them will fill in the state-required blank called "Rehabilitation Potential" with the thudding judgment "None."

The medical model also has implications for the power structure within a nursing home staff. Because the director of nurses has access to medical information, she often becomes the de facto administrator. Social work is regarded as an ancillary service; in my facility, for instance, social histories and progress notes are still charted under "Miscellaneous Records."

The possible roles for a social worker in long-term care are myriad. The taking of social histories can be merely paper compliance to the mandate to identify medically-related social and emotional needs; it can also be a vital part of the team approach. Staff training and development is an important way for a social worker to share knowledge, to teach problem-solving, and to affect the environment in which staff works and residents live; it seems to me that a social worker must work to teach all staff to do social work, since all staff are, hopefully, interacting with residents, often on very intimate terms. A social worker is often the logical staff person to handle complaints from residents and families, to funnel them to the appropriate person, and to follow through on appropriate action; should complaints become formal grievances, the social worker is the logical choice for membership on the grievance committee. Similarly, the social worker may often be the person most skilled in handling intra-staff conflict, particularly when the administrator, as is so often the case, has no skill or interest in human relations.

Social workers of course become involved in all kinds of counseling with residents and families. Because of the nature of our positions and particularly the very limited time we have, I prefer to think of this function as "counseling" rather than "therapy"; it seems to me that the appropriate function of a social worker in a nursing home is to refer persons needing indepth therapy to local mental health centers and other community resources, and then to monitor the effectiveness of these referrals.

Because my training is in community organization, I find it most useful to regard a nursing home as a community, to assess its viability by use of the general systems approach, and to plan professional intervention accordingly. A nursing home can be seen to meet all the theoretical criteria for a community. In terms of sheer size, most nursing homes — considering residents, staff, and families — have populations the size of many small towns. Nursing homes have boundaries, many of them rather rigid. They have norms and values often clearly developed. Communication systems, both formal and informal, exist and can be analyzed. Within a nursing home are numerous sub-systems — the residents and the staff, the various departments, the associational sub-systems of those who work together to get things done.

Regarding a nursing home as a community leads us to the consideration of interventive strategies outlined by Perlman and Gurin in 1972. According to these authors, four different strategies can be isolated in terms of community organization practice. The first strategy has as its goal the strengthening of community participation and decision-making; it assumes that all subsystems within the community have the same basic goals and can work together to improve their common environment. In some ways and under some circumstances, this strategy can work in a nursing home; active Resident Councils and Employee Councils can be effective outcomes.

The second strategy focuses on improving communication, implying that once we understand each other we can agree and work together toward a common goal. While it is certainly true that many interactional problems are caused by faulty communication, and the expertise of a social worker can often be helpful in improving this dynamic, I am becoming increasingly cynical about the magical powers of good communication. Sometimes I can understand you very clearly, and you me, and still our problems with each other do not seem to vanish.

The third strategy outlined by Perlman and Gurin, which has been called community planning, aims to improve the delivery of services. This is often most effective both within the system of the long-term care facility — as when clothes are disappearing in the laundry or meals are consistently overcooked — and outside. Social workers have a professional responsibility to work with the general community to develop and effectively maintain resources for older persons.

Finally, the fourth strategy is social action. This is the strategy of revolution. Its aim is to change power relationships and resource dispersion, and to help disadvantaged clients to gain greater access to goods and services. In nursing homes, as in most relatively closed systems, this kind of strategy must be employed with a certain amount of subtlety, but it can have some fascinating results, as in the case of one Resident Council I know who was partially responsible for the removal of an imcompetent and oppressive administrator. It is to the credit of the social work designee in that facility that most people never suspected the extent of her facilitator role with her Council.

In most cases, a social worker in long-term care will employ all of these strategies at one time or another. The first two approaches, which assume common interests and can be called "locality development," as used when a social worker consciously works to develop a team approach, when she is engaged in public relations, when she works for such things as increased medicaid reimbursement. Community planning, focusing on the improvement of service delivery and assuming that problems can be solved rationally, is in evidence when intra-systemic problems are worked through, as well as in efforts aimed at the larger society — for example, a recent campaign in Colorado to persuade Medicaid to pay for dentures, hearing aids, glasses, and other prosthetic devices. Social action is employed when a social worker functions as resident advocate, a role in which it is often quite appropriate for a social worker to take a stronger stand in defense of individual rights and liberties than he/she may truly feel on a personal level, in the mere interests of having some voice that can be raised on that side of the issues.

One criterion used by theoreticians to determine the viability of a system is the flow between that system and others; is the output from this system providing input for another? I have found it helpful occasionally to consider the nursing home in terms of the linkages it has, both as a system and for its individual residents and staff members, with the nine general social systems discussed in much social work literature. There social systems are the religious, the recreational, the legal, the political, the economic, the health, the educational and the associational (families, friends, etc.) It is often the responsibliity of the social worker — hopefully with creative support from the administrator — to see to it that linkages between the nursing home and these general social systems are open, two-way, and active.

The primary function of a social worker in the long-term care setting, as in any other area of practice, is the maximization of human potential. We must work hard to keep ourselves and everyone else keenly aware of the subtlety, complexity and ultimate mystery of human beings. And of course, always, the ultimate goal of social work is to work ourselves out of a job.

GRIEF AND GROWTH

Coordinator: Arlene J. Weimer, Ph.D., Chief Psychologist, Geriatric Treatment Ctr., Colorado State Hospital, Pueblo.

Resource Persons: Sister Mary Conter, M.A., Colorado State Hospital Hospice Team, Pueblo: Roberta Ice, Denver, CO; Kathleen Kuni, PH.D., Dept. of Preventive Medicine, Univ. of Colorado School of Medicine, Denver; Florence Evelyn Much, Widow, Denver, CO; Lynne Ringer, CanSurmount Coord., American Cancer Society, Denver, CO.

Recorder: Peg Hatfield, Director, Linn County Retired Senior Volunteer Program, Albany, OR.

Defining grief as the breaking of a relationship with another person, a self image or an ideal, the coordinator developed the concept that the acceptance of the grief process could lead to growth through which the individual could become more mature. This maturity should lead to an expansion of potential for love and learning and building of a new life.

"It is necessary to experience the lonely despair of loss before we can begin the upward climb," Arlene Weimer pointed out. "The royal road to dementia is not letting go of grief."

Chronic grief brings on illness, mental disorders and even criminal acts. Grief was defined as known loss. The young housewife who had undergone a mastectomy experienced deep depression with the loss of part of her body. She learned to live one day at a time, learned to listen and talk with others. Now she works with "Reach to Recovery".

A cancer victim expressed her grief upon losing the ability to bear children following surgery. Her friends, family and faith carried her through the grief process and changed her life.

The aging process often engenders a grief situation. The elderly lose so much—companions, physical power and status. It is well to help them subsitutte other capabilities—compassion, the art of listening service to others. If they can be helped to achieve these capabilities and to cope with the slowing down process, adjustment comes easier.

Sister Mary Conter, a chaplain's assistant, had watched her father die of cancer, had seen loss of life and watched people face death. She learned to listen and to work with families to help them find faith and hope and new interests.

A woman who had spent her life as a housewife and mother described her experience when the death of her husband left her with the responsibility of making a living for herself and children. She outlined the process of her grief through shock, acceptance of loss and determination to go forward and create a new life style.

HANDLING IMPAIRMENTS IN SPEECH, VISION AND HEARING

Coordinators: James H. McCartney, Ph.D., Asst. Prof., Dept. of Speech Pathology and Audiology, Calif. State Univ., Sacramento; Bonny Russell, Ed.D., Prog. Dir., Gerontology Educ. and Training Ctr., San Jose State Univ., CA & Eleanor Tattersall, Speech Pathologist, C.C.C., Alameda, CA.

Resource Persons: Eileen Hancock, M.S.W., Regional Consultant, American Foundation for the Blind, San Francisco, CA; Ralph Leutenegger, Ph.D., Prof., Dept. of Speech Pathology and Audiology, Univ. of Wisconsin, Madison; Gay Nadler, M.S.W., Social Worker, San Francisco Senior Ctr., CA.

Recorder: David B. Jack, H.B.A., M.A. candidate in Family and Community Medicine, Rocky Mountain Gerontology Ctr., Univ. of Utah, Salt Lake City.

Physical changes such as speech, vision and hearing loss often cause a needless segregation of the elderly from the normal social activities of a community. This workshop presented an overview of the problems leading up to this segregation and proposed solutions to these problems.

Eileen Hancock discussed the demographics and implications of blindness in the elderly. By the year 2000, there will be 300,000 cases of geriatric blindness. In fact, the majority of new cases of blindness occur in people over the age of 65. However, these people use less than nine per cent of the resources allocated to help the blind.

Most people experience some changes in vision and hearing around age 60 to 65. So it is only natural that the fear of blindness is great among the elderly. More than 750,000 people over 65 have a severe visual impairment. These vision problems are usually more prevalent in women, minority groups, non-farm workers and those with poverty level incomes.

Legal blindness is defined as an eighty per cent loss of normal central vision. Often this can be estimated by a person's inability to read newsprint, even with glasses. As a result of blindness, the aged are isolated, forced into idleness and made to live on a reduced income. Withdrawal in the elderly is commonly thought to be due to behavioral change, when, in reality, it may simply reflect some degree of blindness.

Under sponsorship of the American Foundation for the Blind, centers have been set up to provide training and counseling services for social workers, public health nurses, nutritionists, etc. At these blind centers, professionals, technicians and others are taught the proper methods to use when working with the visually handicapped. "Talking books" (records of novels, magazines and other publications) are also available at this center. The goal of the blind center is to move patients out of "blind" programs as rapidly as possible and place them back into a normal daily routine, despite their loss of vision.

Diabetes, retinal degeneration and cataract formation are the major causes of blindness today. Glaucoma, another disease which can result in blindness, can be prevented by proper medical care. Yearly screening tests for glaucoma are advised for all people older than forty.

The psychological losses resulting from blindness are great. The feeling of personal worth decreases, independence is lost, individuality and security diminish, and there is a reduction in privacy. It is only by the integration of social services and community resources that these losses can be effectively treated and overcome.

In dealing with the speech problems of the elderly, Ralph Leutenegger emphasized the fact that all aspects of the patient must be considered. Biological, sociological and psychological variables each contribute significantly to a total picture of an individual, and each may be responsible for a speech deficit. For instance, biologically, tooth and gum decay may result in illfitting dentures. The auditory canal may shrink. Arthritis may cause pain. The cardiovascular system may pump less blood causing a decrease in activity; the respiratory system may lose elasticity. Psychologically, a person may let fear, self-esteem or personal identity affect his speech. He may simply not have (or not want to have) the input of sensory stimuli necessary for a proper response. Sociologically, the setting certainly influences speech. Nursing home environments, hospital environments and home environments all elicit different speech behavior.

The first step in overcoming a speech problem is to prepare a therapy program which combines the suggestions of several different professionals. Such a team of professionals might include a gerontologist, a speech pathologist, a physician and a sociologist. Some settings may require special in-service training programs to inform the staff as to the best ways to utilize a speech pathologist. A system of charting should be developed that will show the progress of each patient as well as inform the staff of personal problems, such as a restricted field of vision or disease.

One of the problmes that is particularly evident in the elderly is that a speech impairment may be complicated by compounding with several other factors, such as stroke or a language barrier. Many patients bring no social history with them, and the speech pathologist must rely exclusively on medical diagnosis to determine a proper program. If the diagnosis is very specific, this can be beneficial. But if the diagnosis is too general or is only a partial factor in the speech impairment, the treatment program will suffer. In any treatment program, the patient should help to set his own goals.

A significant new inroad in overcoming speech deficiencies has been the development of a system called AMERIND. AMERIND is a method of substituting gestures for words. An everyday example of the AMERIND system might be the waving of the hand to substitute for the words "good-bye."

James McCartney estimated that up to ninety per cent of nursing home residents have a significant amount of hearing loss. Among all people over age 60, this loss ranges from thirteen to ninety per cent, depending on the environment.

There are three types of hearing loss. The first type, conductive loss, describes a blockage between the outside of the ear and the three bones of the middle ear which are commonly called the hammer, anvil and stirrup. Conductive loss can be due to a cold or a stuffy nose. When indicated, conductive losses can be medically treated by medication, wax removal or, in some cases, surgery. The second type of loss is sensory-neuro loss. This is often called nerve deafness or, in medical terms, presbyacusis. Medical treatment for presbyacusis is not as effective as that for conductive loss. Often a hearing aid will prove helpful. Also, learning to lip read may be of some benefit. The third type of loss is neuro-central. This is by far the most serious form of hearing loss.

In describing hearing losses, it is often useful to use the three psychological levels of hearing described by Ramsdale: 1) SYMBOLIC - This is regular speech, such as when one person talks to another or when a lecturer addresses a crowd; 2) SIGNAL - The signal level would include a fire alarm, a baby's cry, and a police siren; 3) AUDITORY BACKGROUND - These are noises like the wind blowing, crickets chirping, a squeaky chair or a fan blowing.

The level of auditory background hearing is the first to go with a hearing loss. The result is that more attention is given to the symbolic and signal levels of hearing. It is said that a person with such a loss no longer has an environmental awareness.

Auditory training and speech reading are the two most useful methods of dealing with hearing loss in the elderly. Auditory training is the process of adjusting to a hearing aid. Hearing aids do not make sounds clearer, only louder. There are changes in the sounds of words which come about with the use of a hearing aid; these new sounds must be learned. Speech reading refers to lip reading and interpreting cues and gestures. By looking at the lips alone, only twenty per cent of speech can be detected.

Counseling with the aged individual and his family will alert both parties to the peculiar problems associated with hearing loss. Understanding the mechanics and the adaptations that must take place after a hearing loss will lessen the burden for all concerned.

As a summary, Gay Nadler emphasized that the common ground of visual, speech and hearing losses was communication. People who cannot communicate normally try to avoid being noticed and become hard to reach. Part of the reluctance to seek services may be due to the harsh labels that are given to organizations *(Center for the Blind; Center for the Deaf)*. Also, a communication-deficient person may feel that such services will attempt to change his lifestyle. The time factor in dealing with the handicapped is a source of discouragement. And, even the therapists and social workers may become fearful and discouraged when they realize that they, too, may become disabled some day. With a strong desire and proper education, the barrier between the community and the communication-impaired elderly can be broken.

TRAINING HEALTH CARE PROFESSIONALS IN GERONTOLOGY AND GERIATRIC MEDICINE

Coordinator: Theodore R. Reiff, M.D., Prof. of Medicine and Head, Div. of Geriatric Medicine, Univ. of North Dakota School of Medicine, Grand Forks.

Resource Persons: Dorothy Fleisher, Doctoral Candidate, School of Social Work, USC, Los Angeles, CA; William A. Read, Ph.D., Asst. Prof., Dept. of Community Dentistry, Univ. of Washington, Seattle; Rachel Scott, R.N., College of Nursing, Univ. of North Dakota, Grand Forks; William Simonson, Pharm.D., Asst. Prof. of Pharmaceutical Science, School of Pharmacy, Oregon State Univ., Corvallis; Dean Harry Ward, Univ. of Colorado School of Medicine, Denver; Harry Weinstein, M.D., Mt. Zion Hospital and Medical Ctr., San Francisco, CA.

Paper Presentation by Dorothy Fleisher and Barbara Kaplan.

There are several issues of policy that I believe must be confronted before we can identify what education and training is needed for health care professionals and specifically for social workers. How these issues will be resolved will determine what the curriculum should include, and how the course content should be focused.

The first issue concerns the use of the professional expertise of the allied health care professionals. The second, is related to the model of service delivery best suited to the care of the elderly. The last question raises for consideration our distribution of manpower. Each of these areas will be viewed from the perspective of a social work professional.

Let us look at the issue of utilization of expertise. Within the professions a division of responsibility is occurring that enables more qualitative use of the professional's knowledge and skills. We have seen the development and use of paramedics, as well as the expansion of social services through the differential use of volunteers, para-professionals, bachelor's level professionals, etc. However, the lack of collaboration amongst the various professions in the health care field mitigates against the maximum and qualitative use of expertise of each of the professions.

For example, in May 1975, Melvin Glasser, president of the National Conference on Social Welfare stated, at their annual meeting that was focusing on the health care delivery system, that the American Medical Association estimated that a physician spends only "...half of his time on doing what he was trained to do...seeing patients. The other half of his time is spent on business and insurance matters, social, psychological and related situations - for which he was not trained." Dr. Maurice Fox, writing in *Newsweek*, reaffirms this and states, "Many patients go to doctors with no real bodily ills, but are depressed and fearful. Their lives may be painful, empty and disappointing. Often the physician can do little to make these patients feel better. When all the examinations fail to turn up an organic abnormality, the patient is often frustrated and angry."

Unfortunately, this public image of the medical profession is that its members can cure all ills, physical, social, psychological and economic. This must be a burdensome responsibility to bear, especially when one's training and expertise are primarily focused in the biological sciences, and one is constantly called upon to help with the problems of social and psychological functioning of older persons. In contrast to this inappropriate use of, and over-utilization of, the medical profession, Glasser points out that there are more than 3 million allied health professionals...including social workers...whose potential contributions are underutilized.

The challenge to the allied health care professional, and to the social work profession specifically, is to see that each profession builds into its own curricula some understanding of the special knowledge base, and the training in the specific skills, of the other allied professions. This, hopefully, would foster and encourage more qualitative use of the expertise of the varied professions...to the benefit of the patient/and/or/client.

In considering the second issue, the model of service delivery, there are two problems that impact on the elderly persons seeking services. The first is the effect of specialization within professions, and the second is the effect of the lack of a unified plan, amongst professions, for the provision of continuity of care for elderly persons.

Agreed that specialization within the professions promises greater expertise within a narrower arena. But what does this mean for the elderly person seeking help? Considering that most older persons tend to have more than one medical problem at a time, the possibility of being shunted from one department to another, from one professional to another, increases considerably.

In addition, we know that simultaneously with coping with medical problems, older persons are usually also facing changes going on in other areas of their life, which are interacting with their ability to cope with their illness. For example, a broken hip may trigger a prolonged depression. Not necessarily because of the confinement imposed by the condition, but because of the meaning that this temporary loss of autonomy and freedom carries for the older person. The fear that this is IT...THIS is the beginning of that downhill slide toward the end that one has heard was inevitable. It is *this* that serves to aggravate their physical condition...interfering with the recuperative process, while providing the seeds for the sprouting of a sudden and inexplicable full blown depression.

I can recall the time when specialization in social work meant that one family might have several workers. One for the children, and a different one for the parents, while any problems at school or in the economic arena might involve still other workers. It was not until family counselling, with its base in group work skills was adopted as a method of intervention, that the dynamics of interpersonal relationships within the family emerged as a visible factor influencing the behavioral problems of individual family members. The piecemeal approach had precluded seeing the pattern of family interaction that served to contribute to the continuation of the malfunctioning of individual family members.

Thus, whether it is by specialization within a profession or because the treatment is parcelled out amongst professions, the danger exists that we will not involve older persons in their own recuperative processes. What appears to occur instead, is that their anxieties, misconceptions and fears tend to increase...or else they fall between the cracks. This brings us to a recognition of the need for team work as a preferred model of on-going care for older persons, with the allied health professions working interdependently in their service to the total person.

If the team approach were to be more widely adopted, this would mean that knowledge of group work, skills in negotiation, relative to establishing boundaries of clinical responsibility, and the use of the problem solving process, would have to be included in the curricula of those professionals choosing the team model for the delivery of health care services.

Where the first two issues revolved around the qualitative use of manpower, and its ramifications for the provision of services, the last issue, looks at the maldistribution of that manpower. As we know, there is a serious shortage of health care manpower in some of our inner-cities, as well as in our outlying and rural communities. One need only read the NASW...Natl Assoc. of Social Workers...News, to see the number of available jobs that go begging in rural communities and small cities, to appreciate the maldistribution of our needed professionals.

Keeping this in mind, and considering what a task force of the American Medical Association estimated that it costs to train a physician...$100,000...and 90% of that is done with public money...and also keeping in mind that the National Institute of Mental Health has been the major federal source of funds for the education and training of social workers...(I am certain that these conditions prevail in reference to some of the other health care professions as well) then we must ask ourselves...where is the public committment that should accompany the public financing of the education and training of health care professionals?

There has been some discussion of a plan to form health care professional teams and to locate them in areas where their services are desperately needed. As an incentive the venture would be government financed and would include a fully equipped clinic. In addition, provision would be made for housing the professional members family, as well. An added incentive is, that relocating as a team, in a new area, provides some social and emotional support in this challenging assignment. Such a plan would not only enable the professional to complete an obligation incurred with the acceptance and dependence upon public funds, but would also help in redistributing the available manpower to better respond to our national health care needs.

This brings me back full circle to my opening remarks...when I said that there were several policy issues that I felt would influence what health care professionals would be educated and trained to do. If our goal is to be the better distribution of manpower, and the more qualitative use of professional expertise as well as a holistic appoaoch to the care of the elderly, then I believe our curricula and core courses must reflect this focus.

In designing and implementing an educational program for social workers in the field of geriatric health care, several key considerations emerge, which I would like to discuss with you today.

First, we need to identify, in what arenas will the social worker practice? Presently, social workers serve in community based settings such as mental health centers, public health departments, family service agencies and multi-purpose senior centers. They also practice within institutional settings such as hospitals, nursing homes and residential care facilities. Increasingly, social workers are called upon to work as part of a team. To what extent these teams will be able to adopt an integrated approach to case management and to overcome the traditional hierarchical model of collaboration will depend, in part, on the kind of preparation social workers, as members of the team, receive.

This leads us to a second consideration. What is the role of social workers? The primary responsibility of this profession is to respond to the needs of the total person, in a way that other professions, because of their different concerns, are unable to. This means working to promote change not only in individuals or families, but within organizations whose practices and policies may negatively impinge on the lives of people. Because the tools of the social worker are not visible, many mistakenly feel that anyone can do social work. After all, doesn't social work just involve speaking with people, letting them know what is available in the community, like a directory assistance operator, or making arrangements for transfers from one facility to another, like a travel agent. This view is incorrect. The professional self is the tool of social workers; and their expertise lies in their mastery of knowledge of human behavior and their development of skills in interviewing, making assessments and carrying out appropriate interventions.

Attention to the role of social workers brings us to a third consideration. What knowledge base is necessary to prepare social workers as geriatric health care practitioners?

One major content area involves knowledge about the dynamics of intrapsychic reactions to illness, disability and death. Also needed is information about social and psychological causes of physical conditions as well as the implications of physcial conditions for social functioning. This includes consideration of biological and psychological changes to enable differentiation between the aging process and the disease process. Let me illustrate how knowledge in this area is crucial for the social worker's functioning. A 90 year old woman, who prided herself on her independence, was hospitalized and underwent surgery. Reacting to her removal from familiar surroundings, and the trauma of surgery, she began to hallucinate. The nurses, not trained in handling psychological reactions, found it extremely difficult to deal with this woman. Fortunately, they were familiar enough with the expertise of the social work department to request a social worker to intervene. The social worker was able to help this woman discuss her fears which helped to stop the hallucinations.

A second important content area in knowledge about family dynamics, intergenerational relationships and cultural variations. An example can serve to illustrate the importance of attention to family dynamics. A gentleman, recently transferred to a long term care facility, appeared confused and disoriented. As part of the admissions process, a social history was taken by the social worker. In speaking with this man, she learned that he was concerned about the well-being of his retarded son who was institutionalized and had no one other than his father to care for him. The social worker helped make arrangements for the son's needs to continue to be met, and the man's confusion disappeared.

Knowledge of community based resources, including natural helping networks, is a third essential area. An often neglected aspect of social work training is the information and referral component. Because it is the point of access into the health care system, it required special emphasis in curriculums to prepare highly skilled workers in this area.

Fourth is the development of skills in techniques of intervention, based on a systems approach to assessment. Social workers must be equipped to intervene not only on an individual level, but also on a group, family, organization and community level. For example, in establishing a health center in a Mexican-American neighborhood of Denver, social workers, in conjunction with other health care professionals, talked with neighborhood people about their problems and expectations. Because the people feared and distrusted secret places and wanted to see what was happening to everybody, the doctors and counselors worked in an open space, recordkeeping was visable to all, as was the medical and dental laboratories.

The development of skills to enable social workers to function effectively as team members, supervisors or administrators is a fifth essential area. As the concept of neighborhood based, walk-in, multi-purpose health care centers becomes widespread, the need to utilize manpower effectively and efficiently to deliver a range of social and health services becomes essential. One model involved the masters level social worker as coordinator, supervising several teams comprised of bachelor level social workers, volunteers and paraprofessionals who deliver social services, such as friendly visiting, transportation and counseling.

A sixth area in which social workers must develop expertise is research. The ability to document unmet needs, as well as evaluate a program's effectiveness is necessary if creative innovations addressing the needs of people are to occur.

Finally, social workers must be familiar with and able to take positions on social policy issues, such as the desirability of different national health insurance schemes; or proposed changes in federal and statewide administration of Medicare and Medicaid; or the development of local comprehensive health plans.

Having explored the content to be included in preparing social workers as geriatric health care practitioners, we need to consider a fourth, related area. How should training programs be implemented?

First, how should we interest the social work students in working with the elderly? Experience has shown that once students have been given the opportunity to work with older persons, they have become excited by and committed to the field. This means that in undergraduate education, we should be introducing field experience in geriatric health care settings in freshman and sophomore years. However, the provision of concurrent seminars to deal with feelings aroused by what may be for some their first intimate encounter with the aging process and death is necessary to prevent negative attitudes from crystallizing.

Second, how should we develop an interdisciplinary training approach? What incentives need to be offered to professional schools to encourage them to set aside traditional boundaries and develop integrated field placements? As legislation providing for national health insurance is considered, should we be promoting the inclusion of incentives to professional schools, such as funding for research and demonstration projects, to encourage this type of development?

As health care agencies search for methods of modifying the health care delivery system so that continuity of care is indeed provided, should we be working with them, to introduce the concept of geriatric units, comprised of health care professionals, including professional social workers and students, to assess and treat older persons as part of major general hospitals, community based public health departments, and long term care facilities?

Third, what type of continuing education should be provided and to whom? As social work liscensing laws are enacted in more and more states, it is inevitable that regulations requiring continuing education will follow. Should we be working to influence provisions for the type of education required, such as the inclusion of content relating to improving the quality of life of persons living in long term care facilities? How adequate are our methods of providing continuing education. Currently innovative models are being tried. For instance, key leaders, identified by long term care institutions, are being trained to carry on workshops within facilities, with back-up provided by university based educators, as needed.

In conclusion, these two presentations have attempted to highlight the challenges facing social work educators and to relate the demand for a new type of social work professional, one capable of functioning as a team member, to the kinds of knowledge, skills and training necessary to carry out that role.

COPING WITH HEARING LOSS

Facilitator: James H. McCartney, Ph.D., Asst. Prof. of Speech Pathology & Audiology, California State Univ., Sacramento.

Resource Persons: Gay Nadler, L.C.S.W., Social Worker, San Francisco Senior Center, CA; Ric Madsen, L.P.N., B.S.W., Grad. Trainee, School of Social Work, Univ. of Utah, Salt Lake City.

Recorder: Peg Hatfield, Director, Linn County Retired Senior Volunteer Program, Albany, OR.

Hearing loss proves to be a serious handicap to the elderly who tend to isolate themselves: yet it is not as serious to them as to the lifelong deaf who were thought to be mentally deficient before 1960. Statistically, fifty percent of these people are illiterate and socially handicapped. As children they were not taught living skills and their vocations were chosen for them without regard to their abilities.

The plight of the elderly is greatly heightened by deafness. They are deprived of the benefit of social services because they cannot learn about them and as their eye sight diminishes, they become more and more isolated.

While the long-term deaf may have had the opportunity to learn "signing", this would be difficult for seniors. Speech reading that concentrates not only on the lips but the entire facial expression and body language can be a help to those losing their hearing since it is not as difficult to learn as sign language or lip reading.

Those who work with seniors with hearing loss can become far more efficient in their communication by following simple rules outlined by the panel. This includes direct eye contact, listening, modulation of the voice, care in enunciating and concern with change of subject matter so that the senior may be able to follow the train of thought.

Types of hearing aids, both modern and antiquated, were shown and information on choice and care of this prosthesis was offered.

A part of the session was devoted to discussion of the program for the elderly deaf initiated by the San Francisco Senior Center. This was the first program involving the senior deaf in regular programs of a center. Of special interest was the fact that a staff person involved was deaf. She worked closely with Gay Nadler, a social worker, who is adept in sign language. Between them they involved more than 150 elderly deaf in classes, trips and health programs as well as introducing them to the many services available to them.

During the session, the panel members used sign language along with the spoken word to acquaint participants with this communication skill.

PSYCHOTHERAPY

Facilitator: Arthur Schwartz, Ph.D., Director, Adult Counseling Prog., Andrus Gerontology Ctr., USC, Los Angeles, CA.

Resource Persons: Margaret Hickey, Doctoral Candidate in Counselor Education, USC, Los Angeles, CA; Lynne Steinman, Doctoral Candidate in Clinical Aging Psychology, USC, Los Angeles, CA.

Recorder: Kathy Waddell, Student, Univ. of Utah, Salt Lake City.

This session began with Dr. Schwartz discussing the differences between information and referral, counseling, and psychotherapy. He defines psychotherapy as an emotional healing problem solving process. Involvement in this process requires that psychotherapy practitioners have different training and qualifications than practitioners of the other service modes.

Margaret Hickey sopke about Generational differences. She finds that as people age, their standard coping mechanisms no longer work in crisis situations. This problem is compounded by the fact that individuals often face more crises as they grow older and by the erosions of individuals' support systems with age.

The staff at the University of Southern California has found that many times aged clients simply need someone who will listen to them with understanding and respect; the peer counseling system was developed to meet this need. Peer counselors are given 50-80 hours of training which stressed basic communication skills such as empathy, warmth, and respect. Group therapy supplements this aspect of the training program; a training manual and a screening device for selecting peer counselors are being developed. Peer counselors also receive extensive training in the basic facts of aging. Supervision of peer counselors consists largely of reinforcing, encouraging, and supporting the counselors' efforts.

Lynne Steinman discussed intergenerational therapy. Often, as an aging parent loses the ability to perform activities independently, the child progressively assumes more responsibility for them. But if the child assumes more responsibility than necessary, this can contribute to the further deterioration of the parent's capabilities. An interaction pattern based on learned helplessness can develop, and both parents and children may experience feelings of guilt and resentment. Treatment in such situations begins with a realistic assessment of the aged individual's capabilities and of available resources. Assertion training and behavioral contracting may be used to restructure the interactions between parents and children. It may be necessary to help the parent (and sometimes the child, also) to develop alternative social and support systems. Ms. Hickey has found that in traditional psychotherapy with older adults, transference, counter-transference and power issues are different than with younger clients. However, if the therapist deals with the age issues, good relationships can be established in spite of large client-therapist age differences. Most elderly clients put aside age and other prejudices very quickly if they feel that they are understood.

EDUCATION: A CITIZEN/PROFESSIONAL CONCERN

COMMUNITY COLLEGES: CONTEMPORARY EDUCATIONAL PROGRAMS FOR THE MATURE

Coordinator: James Gibson, Ph.D., Dean of Continuing Education, Pima Community College, Tucson, AZ.

Resource Persons: Susan Altman, Coord., Sr. Citizens Consortia Proj., Mesa Community College, AZ; Neil Burell, Ph.D., Dir., Emeritus Institute, Coastline Community College, Fountain Valley, CA; Connie Howard, Dir., Community Services, Pima Community College, Tucson, AZ; Selma Zarakov, Coord., Prog. for Older Adults, Palomar Community College, San Marcos, CA.

Recorder: Bill Montgomery, Graduate Student, Leonard Davis School of Gerontology, Univ. of Southern California, Los Angeles, CA.

This was a wide-ranging workshop, including discussion of such issues as recruiting, financing, staffing and program content.

Little was said about designing curriculum on the basis of a pre-conceived classification of the educational needs of older adults. Instead, speakers suggested designing curriculum on the basis of whatever classes senior citizens demand of the college. The advantage to this is that money is not committed to classes that the school perceives as needed by the older population, but has no indication as to how they will be received. Instead, the school concentrates on classes for which an active interest has already been shown. This direct response to what seniors demand may generate greater community interest in the program, but may also do little to meet the educational needs of non-elite students. Such students may not express their needs to the college either because of ignorance, lack of organization or resources, or community black-listing. It was suggested by participants that instead colleges should formally survey the educational needs of their entire service population, and address those most keenly felt. Several participants expressed the sentiment that "Those least able to survive need our help first."

Whether classes should be for credit or non-credit is based not only on the economics of education but its philosophy as well. Economically, some schools must offer only credit classes, so as to qualify for payment based on Average Daily Attendance. If it is not necessary to make senior classes pay for themselves, however, many argue against the credit arrangement. They claim that credit courses create anxiety and alienation in many elderly individuals. Others state that offering a course for credit compliments the older students' abilities and helps encourage competitiveness, which they see as a healthy attribute. If the elderly don't want credit, they can always withdraw just before the end of the course, if they are aware of that option.

Many colleges are scheduling intergenerational classes, avoiding what one participant called "generational apartheid." Among the advantages for such classes are the facts that both young and older students tend to be more motivated by this format, tend to learn faster, and that seniors are enthusiastic about and stimulated by such interaction. Among the disadvantages are the facts that it is difficult to schedule the classes at times convenient for all ages, and it is frequently difficult to get the young into institutions such as retirement hotels and nursing homes.

Should Community Colleges include advocacy in their programs? It was generally felt that colleges are charged with the job of creating an informed citizenry, but participants were divided on whether schools should stop at discussing issues, coalescing groups, facilitating group actions, or actually formulate advocacy policies. One college has its seniors do research into specific topics, and then present positions papers outlining courses of action to the community at advocacy seminars.

Some Community Colleges see their role as meeting social as well as educational needs. Besides advocacy, such roles may include provision of meal programs or counseling services. Some schools sponsor Senior Centers, some of which are staffed by their own Gerontology students and are located either on or off campus. Several of those on-campus centers have developed re-entry programs to help older students get acclimated to college.

Transportation is another service that is occasionally provided. Some schools have their own busses and drivers, and may provide transportation services for the local Area Agency on Aging as well as for their students. In some areas, RSVP volunteers drive busses that belong to local organizations or churches, and the colleges pay for insurance and gas. One school doesn't provide transportation but awards scholarships to senior citizens needing assistance in defraying expenses incurred by attending classes. Donations from local organizations supply the funds for the scholarships, which usually amount to $25 each.

Available safe and inexpensive transportation may help increase attendance in a senior program, but other strategies must also be used frequently. Among those used by the Community Colleges for recruiting were: 1) intense public relations campaigns directed not at the usual publicity channels, but at places where seniors tend to visit and congregate; 2) sponsoring festivals or open-houses on campus for the elderly to familiarize them with the setting; 3) involving the seniors in developing the program; 4) reducing barriers to attendance, such as long enrollment procedures, parking restrictions, and activity admission fees; 5) providing for the involvement of seniors who may not be entirely "tuned-in"; 6) developing an Emeritus College, where the elderly teach each other; and 7) possibly charging a nominal tuition fee for all classes, since senior citizens in some areas dislike any form of hand-outs.

A wide variety of funding arrangements for senior programs was represented at the meeting. In many situations, colleges are restricted to presenting only classes that can support themselves through tuition or Average Daily Attendance payments. Other colleges are not restricted by such requirements, but must never-the-less efficiently use funds. The need to prioritize goals was emphasized, since Community Colleges cannot be all things to all people. Alternatives to the funding crunch may include the use of volunteer teachers, mass media presentations to alleviate the need for as many class sites and resource centers, and even distribution of the educational responsibilities for an area through a consortium. It was suggested that participants read "New Dollars for Community Colleges," by M. Dale Hansen, in the Journal of Community and Junior Colleges, December, 1976-January, 1977 issue.

The consortium is a growing phenomenon at the Community College level. Senior programs can benefit from such an arrangement through better impact on government agencies, pooling of resources, writing joint grants, and coordinating curriculum. The main disadvantage of the concept is that of most committees—conflicting priorities.

Staffing patterns of senior programs varied widely, from all volunteer to situations with paid staff and administrators. Some programs enlist the help of senior citizens, RSVP volunteers, college interns, or individuals in CETA programs. Some schools question the use of senior volunteers, citing how little dignity there is in doing a job for free that would be a paid position for someone younger than 65. In some areas, seniors cannot afford to be volunteers even if the program is worthwhile. In such cases, the school's policy should reflect the socio-economic context that it is in and possibly scrape up enough funds to at least pay nominal stipends to volunteers. This policy may be necessary in regard to teachers, too. Emeritus teachers may be offended when they learn that younger teachers are being paid $10-$15 an hour for the same work that they are doing for free.

EXPERIMENTS IN LIFETIME LEARNING

Coordinator: Douglas Rich, Director, Fairhaven College Bridge Project, Bellingham, WA.

Resource Persons: Bruce & Betty Bon Durant, Alberta Clancy, Participants, Fairhaven College Bridge Project, Bellinghan, WA; Mary Louise Burum, Director, Our House, Inc., Greeley, CO; Milton Erickson, Director, The Institute for Enrichment of Later Life, Sioux Falls, SD; Leroy E. Hixson, Assoc. Dean, NRTA/AARP Institute of Lifetime Learning, Long Beach, CA.

Recorder: Patricia Grinager, Ph.D., School of Nursing, Univ. of Wisconsin, Milwaukee.

Representatives from four different alternative styles of aiding and abetting lifelong learning enlivened this session: 1) an intergenerational college in northern Washington; 2) a community educational center in eastern South Dakota; 3) an educational institute in southern California which coordinates and counsels satellite institutes in farflung communities, and 4) a local, peer counselling center in northern Colorado.

Douglas Rich, genial director of the Western Washington Fairhaven College Bridge Project, introduced and presented an informative film. Then he let three Bridge participants testify as to the enrichment that living and learning at Fairhaven had brought to their own lives. Four age groups intermingle on this campus: pre-school children, the usual college people from late teens to mid twenties; pre-retirement persons from 25-60, and the real "Bridgers" who range in age from sixty to eighty-two. Older people take regular college courses right along with younger ones on either a credit or non-credit basis. The program is already four years old and going strong. "There's no difference between teaching us and teaching anybody else," Alberta Clancy declared for those elderly everywhere who hunger for learning opportunities like this one.

Milton Erickson enumerated four functions of The Enrichment of Later Life (TELL) program that he conducts in Sioux Falls, South Dakota. Older American education, retirement planning, gerontology program, along with consultation and technical assistance. The center makes available slides, tapes, books, courses, counselling services, and a speakers bureau. It is a charter member of the Institute of Lifelong Learning.

Leroy Hixson described the Institute of Lifelong Learning which was founded fourteen years ago in Long Beach, California, by the NRTA/AARP. The organization fosters locally-oriented, low cost, extension institutes throughout the country. It encourages cooperation between its various satellites and local community colleges. In some cases, mini courses have even been published in neighborhood newspapers. Mary Louise Burum heads "Our House" in Greeley, CO. Her center trains senior aides for peer counselling in such areas of concern as assertiveness, identity, and leadership. A current endeavor involves beginning nutrition services in the area along with dispensing information on such matters as the probable consequences of continual drug use.

CURRICULUM DEVELOPMENT ON AGING, K-12

Coordinator: Vicki Schmall, Asst. Dir., Program on Gerontology, Oregon State Univ., Corvallis.

Resource Persons: Nancy Benge, Extension Agent, Deschutes County, OR; Kathy Specktor, Dir. of Community Programs, Crossroads School, Santa Monica, CA.

Recorder: Lynn Susoeff, M.A. Program Specialist, Commission on the Aging, San Francisco, CA.

The Coordinator presented an overview on the development of educational curriculum concerned with concepts of aging grades K-12.

While the 1971 White House Conference on Aging recommended that education for aging should be developed to fill this need, efforts to introduce aging concepts in the educational curriculum have been isolated. Two hurdles which have impeded progress toward this goal are:

(1) Lack of formal training for teachers on aging concepts.

(2) Inability of administrators to add courses to already crowded curricula.

Studies conducted to assess the attitudes of the young toward the elderly indicated the importance of introducing concepts of aging into the elementary school curriculum in order to counteract the negative stereotype regarding aging which is due in part to the lack of contact between younger and older people.

The following guidelines have been developed in planning an aging curriculum for grades K-12:

(1) Aging concepts should be incorporated into the total curriculum rather than limited to a course or unit of work.

(2) The curriculum should provide a broad perspective of aging with an understanding of the psychological, social, economic, and physical aspects of aging.

(3) The curriculum should include a realistic view of aging including both the positive and negative aspects associated with aging.

(4) Interaction between the student and older people should be provided and include a range of experiences.

(5) Interaction should include opportunities for the older person to share his skills with the student and for the student to work with the older person on a project.

(6) All activities in the curriculum should be designed for the developmental level of the student.

(7) Four areas of understanding concommittant with the aging process should be included within the curriculum:

a) the student should understand his own attitude toward aging

b) the student should understand the changes people experience as they age

c) the student should recognize the similarities and differences between himself and older people

d) the student should understand the social milieu in which older people were raised

Presentations were made on two innovative educational programs concerned with aging.

Nancy Benge described a program in Deschutes County, Oregon which studied the effects of workshops on aging on the attitudes of 5th grade children, high school and university students. A pre-test was administered followed by activities which were used to teach concepts related to aging. Activities were selected to assist students in developing a more realistic understanding of the aging process and to become aware of the problems and benefits of aging. The activities included a balance between the physical, psychological and social changes which accompany aging. Discussions, role playing, writing exercises, and panels were some of the strategies used to teach the concepts of aging.

Kathy Specktor described the Crossroads Program in Santa Monica, California. Crossroads is a private secondary school which has incorporated aging concepts into the school curriculum. Students at Crossroads are provided field experiences and seminars regarding aging between the ninth and twelfth grades. In the ninth grade, the student is introduced to the elderly in an institutional setting. Tenth grade students participate in day care programs for children. In the eleventh grade, students adopt a grandparent. This program is coordinated with the Senior Services Center in Santa Monica. Students in the twelfth grade have the option of staying with their adopted grandparent for another year or doing other community work. Ms. Specktor presented a videotape on aging made by students in the program who had adopted a grandparent.

Curriculum resources and activities on aging were distributed to workshop participants.

Following the presentations, workshop participants had the opportunity to interact with each other and the panel. Several ideas on aging programs were shared by the participants. The participants also recommended that the Western Gerontological Society develop a bank or lending library of curriculum resources on aging which could be used by persons in the development of curriculum on aging.

PRE-RETIREMENT EDUCATION: RESEARCH AND TRAINING

Coordinator: James H. Lynch, Ph.D., Asst. Prof., Univ. of Oregon Ctr. for Gerontology, Eugene.

Resource Persons: Virginia Boyack, Proj. Dir., Pre-Retirement Education Project, Andrus Gerontology Ctr., Univ. of Southern Calif., Los Angeles; Hugh Brower, President, Society for Pre-Retirement Program Planners, Omaha, NE; U. Vincent Manion, Ph.D., Assoc. Prof., Ctr. for Studies in Aging, North Texas State Univ., Denton; Shirley Waskel, Retirement Education Coordinator, Gerontology Program, Univ. of Nebraska, Omaha.

Recorder: Margaret K. Hohu, C.R.N.A., Graduate Student in Gerontology, Univ. of Northern Colorado, Greeley.

Attendance to pre-retirement planning programs has increased as more people become interested in pre-retirement education, research and training. However, special populations in our society have been ignored in the past, or programs geared for this segment have been neglected. Therefore, to meet the needs of the special populations, innovative programs have been and are being developed. These life-planning programs must have meaning to the special groups being addressed and must be flexible to meet the needs of these groups.

Minorities:

Virginia Boyack stated that research showed less than 1 per cent of the minorities were attracted to pre-retirement programs; therefore, a 6-month pilot program was developed for the black population in a given area. It must be remembered that minorities have different needs that must be considered when developing and presenting a program.

The needs of the target group must be identified before a program is started. For instance, research shows that, upon retirement, blacks are more likely to rest, fish, participate in church activities and assist the young people. Whereas, the white population would travel, study, be self-employed, do volunteer work, and golf. On the issue of housing, the black population would own his own home, live in an apartment, or was undecided. The white population were likely to find domicile in retirement hotels, mobile parks or retirement sponsored complexes. Financially, the black population depended solely on their pensions; the white population had other means of retirement income.

Retirement educators must work with special populations who have different sets of needs but, for the most part, have been indifferent to the needs of the different population.

Women:

Another special group are women. Business and industry sponsor retirement programs for couples; however, retirement planning for the "third age of women" within the religious and the non-secular communities has been deficient.

Pre-retirement education for women must be addressed to the participant's role changes and role losses: widowhood, divorcee, empty nest syndrome, nearing of retirement of self or husband, returning to school, returning to work, or working for the first time.

Professional-Society Issues:

As specialties develop and grow, it is inevitable that a "society" of a specialty is formed. A two year old organization called the Society for Pre-retirement Program Planners is now headquartered in Omaha, Nebraska. The purpose of this society is to provide assistance, to congregate and assimilate information, and to act as a clearinghouse for resource persons. Their goal is to set "training standards" to meet the necessary credentials for pre-retirement planner-counselors. Presently, the society is formulating criterions for professional standards and guidelines for counseling, setting up programs, resource people, etc.

Standards:

Vince Manion stated that there is a growing interest in pre-retirement programming, and job opportunities are there; however, the question is, was proper training provided for the programmer?

The roles of pre-retirement programmers should be defined. Are they program planners, program administrators or program presenters? The difference between pre-retirement program counseling and pre-retirement program training must be delineated.

The programs must be designed to fit the needs of the population. There should be a foundation model that can be structured for different special groups. This is a basic model which can be interjected with the special needs of the target mmoup.

Summary:

More and more interest is being shown in pre-retirement planning programs and, as this interest increases, innovative programs are being introduced in an attempt to cover all segments of society. With this increase, organizational, professional, and educational issues are being raised and challenged.

PROFESSIONAL GERONTOLOGICAL DEGREES VS. PROFESSIONAL DEGREES IN A DISCIPLINE

Facilitator: Geraldene Burdman, Ph.D., Asst. Prof., Health Education Dept., Univ. of Oregon, Eugene.

Recorder: Beverly Seeds Little, Graduate Student in Gerontology, Univ. of Southern California, Los Angeles.

It was apparent in this meeting that students who are in graduate school or who are anticipating entering graduate school are questioning the wisdom of majoring in gerontology. There seemed to be a general feeling that there may be less employer interest in graduates with degrees in gerontology than for those with degrees in other disciplines which include content in aging.

Those students who contemplate majoring in gerontology indicated concern as to whether they need to specialize in one area, such as administration, or pursue a more broadly based course of study which would encompass direct service, education and administration. It was suggested that it might not be wise to specialize too closely but rather to leave one's options open.

There was agreement that the trend seems to be toward a Master of Science degree in gerontology and a doctoral degree in other disciplines. Concern was expressed that having a special field concerned with the problems of aging might tend to isolate older people even more from the mainstream of society. If gerontology is incorporated into other disciplines, there might be more widespread interest in the field of aging.

DEVELOPING EDUCATIONAL RESOURCES FOR SENIORS: WHO, WHERE, AND HOW?

Facilitator: Cuma Smith, Director, Campbell Sr. Center, Eugene, OR.

Resource Persons: Clara Collette-Pratt, Ph.D., School of Social Work, Univ. of Washington, Seattle; Donna McKenzie, College of Education, Univ. of Oregon, Eugene.

Recorder: Margaret K. Hohu, C.R.N.A., Graduate Student in Gerontology, Univ. of Northern Colorado, Greeley.

Education may be defined as helping people learn what they want to learn. Educational opportunities for the senior adult may be found in colleges, universities, senior centers, volunteer programs and other non-traditional resources.

Fees and tuitions differ in different areas. For example, community colleges in California are open to anyone and there is no fee for attending; however, in New York there is a charge. Some universities offer "lifetime learning" where the seniors may attend classes or be utilized as consultants, and seniors from all economic and educational levels use these facilities. A contributor stated that her senior center maintains close ties to a university, its faculty and students. Forty different classes are offered free, such as languages, arts and crafts, legal aid and health. Some courses are offered year round and others are presented as the need arises. Instructors for these courses are recruited from the community.

Another contributor found that at her center, the uneducated person preferred short-term sessions of less than two hours in length. Courses offered at this facility consisted of funerals and funeral expenses, normal aging versus pathological aging, drugs, vision and hearing changes, health aspects (adapting to chronic diseases), occupational therapy, and financial estate planning. Short-term education can be offered in facilities such as churches or nutrition sites (not in schools). Current topics may be discussed such as legislation, consumerism, fraud, etc., or nursing homes may be evalutated and discussed as to when to place someone in a nursing home, or when to go to a nursing home. It was suggested that outside expertise is helpful to augment these discussions. The educator must develop programs and help the community resources be responsive to the elderly. Examples are exercise therapy for the elderly, students in health and pharmacy may present talks, or printed information that is geared for the elderly is distributed.

Many courses sponsored by community colleges are held in senior centers, churches and schools in nearby communities. Materials and films are available, and libraries are able to obtain talking books. All resources are available anywhere, including the rural areas, if one takes the time and trouble to seek them out.

There need not be the traditional type of classes as stereotyped by teaching groups. Teaching can be done on a one-to-one basis and not necessarily in groups. One can be willing to share and another to listen.

Educators must remember to teach what people want to learn. At the senior center the teacher is a friend, too. Instructors must gear the classes to the different age levels. Short-term classes (6-8 Weeks) attract the younger elderly (55-65), and the long-term classes (6-8 months) attract the older and slower types (65+).Educational values are different.

In Arizona the local conditions determine whether there are long or short-term classes. There are larger classes during the winter months because of the high influx of the elderly. The trailer parks have a large population of widows, and continuing education is offered with minimum required attendance. The Indians on the reservations need assistance too. Libraries are being explored more in adult education. Some community colleges are making videotapes and placing them in the libraries. Some libraries have 'Dial-a-book' service. Friends of the library will get the books and deliver them to shut-ins. Used magazines are placed on tables in strategic areas for anyone to take, read, and return for others to use. Pre-retirement programs are being offered in many different kinds of settings. A suggestion was made that different organizations and businesses be identified and asked for permission to present a pre-retirement program, without any obligation to the company except for the time period, perhaps during the lunch hour. AARP has received requests from colleges to develop pre-retirement planning programs for union groups. The unions have not been satisfied with the programs they have produced. Furthermore, there has been a tendency of the pre-retirement programs to be management oriented and not labor oriented; therefore, the union has not been keen about the AARP pre-retirement planning program. If there is a valid need for pre- and post-retirement planning for the rank and file, the AARP will develop a course for this group. Many other areas are instituting pre-retirement programs as part of the organization's fringe benefits.

There is a need for learning resources from educational facilities at nursing home complexes for use by residents, patients, and in-service for the workers. Community colleges are becoming more responsive to this need. Many problems arise in the nursing homes because of licensing and the great turnover of personnel. Workers can be motivated by education to make them more competent and viable.

In California, aides are being mandated to attend in-service education. Administration pays for one hour and the aides give up one hour. An example of in-service training was given. A portable unit with a nurse and social worker talks to management to find out what their needs are, then the team talks to the workers to find out what their goals are. The training is then brought to the nursing home. The service is paid for by the hospital. Nursing home educators, administrators, and owners must be made aware of the necessity of this learning process as humanization for all concerned.

Motivation is a key issue in adult education because older adults are more diverse than any other group of people. Find out what motivates them—the educator must keep this in mind. Find out what the person wants to know and what the person is really interested in. And, remember, the older adult must also be involved in work.

The educator should have a form of feedback to evaluate and re-structure the program as required. There is always the danger of reaching a conclusion too soon and not giving the program a fair trial. The educator needs to be in touch with what people say they want beforehand, recognizing that people may not know what they want after they get there and have had the experience, and learn that it is not what they wanted but something else. Get this kind of feedback into your planning.

Summary:

Adult education is lifelong learning. Formal resources can be found in colleges, universities and schools. Non-traditional resources can be found in libraries, senior centers, volunteer programs, extension services, unions, nursing homes and lifelong learning programs. People head the list. People are traditional and non-traditional learners. Motivation is a two-way street. You cannot force someone to learn, but you can create an environment where they can be receptive to learning and where they can be involved. It is important to look at the whole group or institution that you are dealing with and assess what their needs are.

GROWING OLDER IN RURAL AMERICA

NEEDS ASSESSMENT AND REALISTIC PLANNING

Coordinators: Bill Jacomet, Nutrition Dir., South Dakota Office on Aging, Pierre & Ana Marino, Assoc. Planner, Planning and Research Division, TELACU, Los Angeles, CA.

Resource Persons: David Robinson, Exec. Dir., Gateway Office on Aging, Ketchikan, AK; Paul Stuetze, Asst. Admin., South Dakota Office on Aging, Pierre; Robert Ward, Planner, Utah State Division on Aging, Salt Lake City.

Recorder: Marsha S. Crites, Student, Center on Aging, San Diego State University, CA.

This workshop was an exploration of the various methods of needs assessment as a first step and a realistic tool in the planning process. With a focus on implementation in rural areas, limited resources and staff were dealt with extensively and suggestions were provided as to how to overcome such obstacles.

William Jacomet provided participants with an indepth look at how his agency had accomplished a needs assessment by giving the participants of the workshop a packet which included the questionnaire, the planning sequence, public comment forms, and other input documents used in their assessment. The group discussed the use of such methods as random sampling, digital dialing, input from churches, and precinct data.

Robert Ward's presentation dealt with the three aspects of planning: physical, economic and social. He raised questions concerning "the myth of planning," encouraged local aging agencies to apply for other money in addition to AoA money, and stressed the need for more coordination, especially the integration of elderly services with those of other groups.

Ana Marino's presentation centered on methodology suggestions stemming from the *East Los Angeles Transit Needs Study* of March, 1977. Marino stressed the needs for randomization in sampling and provided suggestions on additional sources of data such as from banks, police records, and universities thus building on research already done and cutting the tremendous cost of research.

The workshop discussion added to the list of sources of information and methodology and seemed to focus on the needs for the assessment of needs to be a continual process rather than a one-shot study every year or so. Information and Referral offices were suggested as a place where seniors could fill out a continual needs assessment form. As a final step, it was suggested that shared data banks be set up in areas so that research would be available to all agencies for up to date and realistic planning purposes.

CREATIVE OUTREACH AND INFORMATION AND REFERRAL

Coordinator: Michael Goodroad, Dir., TIE-LINE, Pierre, SD.

Resource Person: Joseph B. Mann, M.S.W., Asst. Prof., School of Social Work, Arizona State Univ., Tempe.

Recorder: Joe Ann Hyer, RSVP Director, Marion County, OR.

Mr. Goodroad opened the session. He displayed a booklet from the South Dakota Information and Referral system and described the stickers and wallet cards that are used.

There are various kinds of Information and Referral: a) all-purpose, general I & R (human services); b) specialized I & R, serving different population groups (elderly, youth) and serving specific problem areas (drug abuse, child abuse, alcoholism); c) all-purpose I & R whereby all agencies do some type of information and referral.

One study proved that two-thirds of all people coming in must be referred to another agency. In following up these referrals, it was discovered that 17% of the service referrals actually received services requested. It is difficult to assure the person referred that the service will be provided.

There are many basic components of a successful information and referral program:

1. A resource file - updated information on available resources.

2. Staff - people that are patient, sympathetic, empathetic, sensitive. People that are able to get complete information and can hear between the words to properly define what the real problem is. Intuition is essential.
3. A stable funding source.
4. Adequate access methods - phone, walk-in, outreach, etc.
5. Working relationship with and understanding of the service providers.
6. A system of accountability; ability to monitor the system and evaluate.
7. Planning and needs assessment process.
8. Find out the needs requested the most and ideally one can plug it back into the process.
9. Some mechanism for training.
10. Develop credibility in the county, area, community, general public.
11. Confidentiality is one of the key elements of a good I & R system.

The South Dakota Tie Line Information and Referral Service was designed from the Georgia Tie Line model. It was set up under the Carter Administration when he was Governor. There is a toll free number to ask about any human services in the state, open 8 a.m. to 6 p.m., 10 hours a day. In-watts line and out-watts lines can be answered by an I & R specialist that asks "nature of the call and where from" and may follow with more questions if necessary to get information on specific need. If possible, that person will answer the question from the file, otherwise they will locate the service agency nearest to the caller (while caller is on hold) and then dial the agency on the outgoing line, relate the problem, then bridge the call on the three lines (tie line, caller and agency). Tie Line stays on the line to make sure that help is being provided. If help is not provided, Tie Line keeps going higher in the agency until caller receives the help requested.

Accountability is essential. A record of every call is made and set up for easy key punch. At the end of the month, they are all tallied so the staff is aware of what the program is providing in terms of services. There is no record of confidential data and forms are destroyed after six months.

Attitude of the staff is extremely important. Good communication in the office is vital in order to provide citizens with the best services. Good office conditions are essential.

If a person calls the Tie Line and reports that the initial call did not solve the problem, then follow up is done. Evaluation of the service agencies is done periodically.

Joseph Mann described Michigan's I & R "Network". The network provides accessibility to services. He described the older adult as a consumer, not a client. A consumer is a user of services and it is important that the consumer be knowledgeable of the services that are available. In a survey of 22 agencies, including I & R, it was found that in the lower income level, there was a definite lack of information about available services. The survey proved that 80% of the persons asked had never heard of Information and Referral; of those that were knowledgeable, (20%), only 10% actually utilized the service (I & R). How do people hear about these services? Service providers must be salesmen and market their services in order to get the message out to the public. Rural areas are most often ignored as geographical difficulties impede communication. Many times, the word is passed along to friends from people who have had a successful experience with the I & R service.

Communications and information-sharing can be facilitated by informal meetings of representatives of the service agencies.

POLITICS, POWER & PRESSURE GROUPS

STRUCTURE, USE AND TRAINING OF ADVISORY BOARDS

Coordinator: Mike Bainbridge, Dir., Area Agency on Aging, Eugene, OR.

Resource Persons: Christina Martell Hurd, Asst. Planner & Trng. Coord., Area Agency on Aging, Eugene, OR; Dorothy Fleisher, Doctoral Candidate, School of Social Work, USC, Los Angeles, CA; Barbara Kaplan, Doctoral Candidate, School of Social Work, USC, Los Angeles, CA; Cuma Smith, Dir., Celeste Campbell Sr. Ctr., Eugene, OR; Rev. Lloyd Stamp, Citizen Advisory Committee Member, Area Agency on Aging, Eugene, OR.

Paper Presentation: by Dorothy Fleisher and Barbara Kaplan.

Dorothy Fleisher and I will be making a joint presentation. As a means of highlighting issues that emerge as a result of the interaction between staff members and council members...we will be presenting a role playing situation.

I would like to welcome you to an executive committee meeting of our Advisory Council. They are now in session and are busy planning the agenda for the next council meeting. The three staff members are sitting on the left side of the platform...and the three council members on the right. After eavesdropping in on the meeting for several minutes, we will open the floor for a debriefing...to discuss what we saw, how we felt, and any other opinions we may have about the process that we observed.

Now let's listen in on the meeting.

From the role playing situation we have just observed, we can see how the pressure of time, the need to respond to community issues, and the varied agendas of individual council members all influence staff/council member relationships. For the next several minutes, I would like to discuss with you some of the crucial areas which effect this relationship.

Let us first consider the attitudes we hold about the importance of Advisory Councils, which in turn, influence the ways we work with these bodies. What are some of these attitudes? Participation is like spinach...no one is against it because it is supposed to be good for you. However, as administrators and staff, with tremendous demands upon our time, we may question the desirability of having an Advisory Council. For many of us, though, there is no choice. We have to as a condition of receiving funding. We may wonder if the results are worth the time and effort. We may question whether council members have the knowledge to adequately discuss the complex issues we deal with. We may feel that, given the pressure of deadlines, we have no time to involve council members before decisions are made. Or, we may be concerned that if we really were to involve council members, it would make our jobs much more difficult as the recommendations might be inappropriate.

Now, lets examine how these attitudes might influence our behavior. In practice, we may tend to limit the scope of responsibilities we assign to Council Members. Incidentally, in a study I did of five Advisory Councils in California, it was found that staff perceived Advisory Council members as being significantly involved in establishing agency objectives, adopting the budget and reviewing grant applications. However, this perception was not shared by the Council Members who saw themselves as having limited or no responsiblities in these areas. Or, we may limit participation by council members, believing that informing them of our plans is equivalent to involving them in decision making. In this regard, in the study I just referred to, it was also found that 90% of the Council members interviewed used the information they were given during meetings in reporting back to community groups. However, only 30% felt that they participated in the decision making process by providing information about their organization's preferences. Or, we may even ignore the expertise Council members do possess. For example, we tend to recruit council members based on their organizational affiliations. Most are active people, officers of at least one other organization, and therefore have experience in leadership positions. However, we may not use our information about members backgrounds in determining who can make the best contributions on which committees. Nor do we systematically draw upon their rich network of linkages to community groups in building support for our programs.

What tends to happen as a result of these attitudes and behaviors? Those persons who are organizationally linked may perceive NO opportunity for real input. If they receive useful information they may continue to attend, but not assume an active role commensurate with their abilities. However, if the information provided is not valuable to their organizations, they may feel their time is being wasted, and may therefore drop out. Ray Steinberg studied administrators and staffs working with Area Agencies on Aging and direct service organizations. He found that both the administrators and staffs of these organizations perceived their advisory council members as reluctant to assume responsibility or become involved in management roles. We might ask ourselves if we have created this problem. For what in fact may be happening is that participants decide not to remain active in organizations that they perceive as not interested in their contributions.

In essence we have a choice. We can adopt a short-range perspective, succumbing to the pressure of our job and limit the involvement of our advisory council members. And we know the problems this can create. We are all too familiar with the high turnover or the bad press we may generate. And, we all know the embarassing situations we find ourselves in when we have prepared reports for our council members to read at hearings, only to have them stop in the midst of being questioned to publically ask us for clarification.

However, we have an alternative. We can elect a long-range perspective, believing that the investment of time and energy will pay off as council members become more knowledgeable and develop expertise. If we choose this alternative, these are some of the things we can do. First, research indicates the importance of orientation and training. We also recognize the value of mailing out agendas and minutes of past meetings in advance, so members can be prepared to participate. And we are aware that for the information to be useful, we need to summarize the major points and direct the members attention to specific areas of concern, so that they focus their reading and not have to plow through a maze of irrelevant material. We also know from research that those councils which reimburse their members for out of pocket expenses are able to minimize the turnover of members. And finally, if we wish to truly involve the advisory council members, research indicates that there are two crucial areas in which responsibility has to be shared. First, having substantial influence over the budget, which means going beyond the requirement for a sign-off to involvement in formulating and debating the budget is essential. And second is assigning members responsibility for the investigation of the communities complaints about the program.

Many of us are familiar with the advantages of adopting the long-range perspective. In seeking funds, we are more likely to be successful when well-informed advisory council members speak out on behalf of programs at city council and board of supervisor meetings. As a means of keeping us from making costly mistakes, we can't underestimate the importance of input from council members. And as representatives of local community groups, council members are the best equipped to interpret necessary changes that are forthcoming, thereby minimizing misunderstandings. In sum, awareness of our attitudes and how they influence our behaviors, as well as adoption of a long-range perspective can go far toward improving relationships between staff and council members.

TECHNIQUES OF ADVOCACY

Coordinator: Dan Lopp, Dir., Utah State Coalition of Senior Citizens, Salt Lake City.

Resource Persons: Richard Tuttle, Community Organizer, Crossroads Urban Ctr., Salt Lake City, UT; Earle Warner, Dir., Clark County Legal Services, Las Vegas, NV.

Recorder: Jeanette Alexander, Student, Center on Aging, San Diego State University, CA.

This workshop was run as a discussion group. Several themes ran throughout the comments made by group members:

Lack of coordination among senior groups, perhaps related to "turf consciousness."

The smaller the group, the more important are personality differences.

Advocacy groups are most effective when they are organized around "what gets people made." Usually this is related to a perceived powerlessness on the part of a group. This perception in itself can be used to organize the accomplishment of limited successes, which may lead to a position of greater group power.

Example: the dilemma of professional versus senior participation. The process of advocacy may be accelerated by the professional emphasizing that group members do for themselves. However, the group's feeling of helplessness may actually be reinforced by a lack of professional information or guidance.

Several comments were made upon the lack of an active advocacy function on the part of Western Gerontological Society. Strategy was undertaken to propose to the organization the incorporation of a resolution-making procedure, by which WGS could advocate social policies related to senior citizens. Several resolutions were proposed, to be later defined by a volunteer committee and presented to the general membership of WGS:

1. Establishment of procedures for presentation, discussion, and endorsement of resolutions by WGS, as an ongoing part of convention format.
2. Concern for the cost of WGS conventions. Suggestions that conventions could take place in university settings, utilizing university housing, classrooms, and cafeterias. This concern was not only expressed on behalf of WGS members, but also as a general measure to contribute toward the reduction of the nation's inflation.
3. Recommendation to President Carter to hasten the adoption of a comprehensive national health service for all American citizens.

Members of this workshop agreed to talk to other members about these proposals and meet back on the next day for a committee report and further input.

HOUSING: HOW, WHY, WITH WHOM?

RURAL HOUSING

Coordinator: Paul G. Windley, Arch.D., Asst. Prof. of Architecture, Kansas State Univ., Manhattan.

Resource Persons: Harold Freshley, Ph.D., Research Specialist, Ctr. for Research in Social Behavior, Univ. of Missouri, Columbia; Eugene Kremer, M.Arch, A.I.A., Head, Dept. of Architecture, Kansas State Univ., Manhattan; Larry Steel, Research Asst., Kansas State Univ., Manhattan.

Paper Presentation: "Rural Housing for the Elderly: Invisible Problem" by Eugene Kremer

Rural housing for the elderly: our discussion may be well served if, before going further, we examine the way in which we will be employing the terms *rural, housing,* and *elderly.*

The federal government's Farmers Home Administration (FmHA) has long defined rural for its purposes as open country, and places with population of 10,000 or less that are rural in character and not closely associated with urban areas. More recently, some 350 other communities of between 10,000 and 20,000 population which are outside Standard Metropolitan Statistical Areas (SMSA) have been designated rural by the FmHA.

Housing is, in the minds of many, thought of as synonomous with dwellings. It is this view which has played a major role in the environmentally disastrous development of many of America's communities, urban and rural. The dwelling unit is an integral element in the larger complex of social, economic, and physical systems which are requisites of successful housing. Although the prelude to the federal Housing Act of 1949 acknowledged that reality by setting forth a national housing goal of "a decent home and a suitable environment for every American family," vast numbers of dwellings have since been built in this country with inadequate concern for the infrastructure needed to effectively support them.

The elderly, for the purposes of this discussion, are the more than twenty million persons in America whose age is 62 or more. Contrary to popular myth, and as most of you know, nationally more than 95 percent of the elderly live in relatively unassisted and independent settings (Atchley 97). The proportion of rural elderly in non-institutional housing exceeds the national figure.

Many of the rural elderly can recall Franklin Roosevelt's statement describing one third of America as ill-housed. And, these citizens have witnessed the spectacular post-war growth of the economy, and of the housing stock spurred on by direct and indirect housing subsidies to the middle class and the poor. Improvement in the quality of housing in America since FDR's depression year observation was undeniable, yet in 1968 several independently conducted studies estimated that six to eight million families lived in what the Bureau of the Census defined as substandard dwellings (Schafer 2). The Housing and Urban Development Act of the same year established a decade long program for achievement of the 1949 goal. Twenty-six million housing units, six million of these for low and moderate income households, were, it was declared, to be built or rehabilitated by 1978. The goal will not be met.

Despite record construction and subsidy levels during the 1970-73 period, the needed pace was not being achieved. Then, in 1973 the federal moratorium on housing subsidy programs and the impact of double digit inflation combined to slow housing production to a small fraction of that needed. Clearly, even the apparently unattainable goal established by Congress in 1968 is a conservative one, for the Bureau of the Census definition of standard housing is far less demanding than are definitions established by most state and local housing codes. A 1973 MIT-Harvard Joint Center for Urban Studies report estimated that as many as thirteen million households should be classed as inadequately housed when excessive housing cost burdens were considered in addition to code issues (Birch).

No matter what the precise magnitude, the housing problem is immense in scale and it presses most heavily on certain segments of our society. One fruit of the post-war baby boom is the current record rate of household formation.

These formal and informal family units are typically in the low and moderate income ranges and are competing for an increasingly scarce and expensive commodity. While gross median family income increased somewhat more than 200 percent from 1955 to 1975, the cost of mortgage interest, utilities, income, sales and real estate taxes has risen more than 300 percent in the same period (NAHB 5). The elderly are often living on fixed, or nearly fixed, incomes and so are even more severely impacted than the young by housing inflation.

Their predicament is compounded by the state and federal regulations under which banks, savings and loan associations and other mortgage lenders systematically deny the elderly equal access to the housing credit available to younger members of our society. In rural regions, credit is generally far less available than in metropolitan areas. Savings and loan associations which focus on mortgage lending are often not available; instead these areas are served by commercial banks that are restricted by law in the proportion of assets which may be devoted to housing finance. Such institutions are characteristically reluctant to make long-term loans, and so rural borrowers often face higher monthly repayment costs than their urban counterparts (Schafer 5).

The images of the inner city slum and of the cosy farmhouse are counterpoints in America's mythology. It is rural America - largely unseen, or at least unreported, by the popular press and television - which has one quarter of America's people and two thirds of the nation's deteriorating or delapidated dwelling units; and 90 percent of the housing lacking adequate plumbing (Rural Housing 1).

Elderly people who have completed their mortgage payments sometimes find that the rising costs of taxes, utilities, and house repairs strain their resources. Often their homes inadequately meet needs which emerge as they age. Stairs increasingly present barriers to internal mobility, and the responsibility for maintenance grows progressively more burdensome. Because the construction market is geographically dispersed in rural areas, skilled artisans and building materials needed to adapt such dwellings, or to build new structures are often in short supply or must be transported long distances, thus further increasing the financial burden on the elderly.

The low density and geographic isolation which characterize rural areas can also make access to transportation, energy, sanitary, social, recreational, and health services expensive. Isolation from these services, and from friends and relatives - especially if children have left the home and the spouse had died - is made more critical by the diminished mobility of many of the elderly.

The litany of issues outlined thus far does not overstate the magnitude of the problems confronting our society in efforts to respond to the demand for rural housing for the elderly. Regional, ethnic, and individual differences, and rapidly changing needs, among what is in many respects the most heterogeneous age group in the larger population, compound the superficial difficulties and make evident the need to accommodate a broad range of life styles by assuring the elderly a variety of housing choices.

America's urban/rural population balance, spurred by industrialization of industry and agriculture, had moved on a seemingly inexorable course from the countryside to the cities since the late eighteenth century when barely one American in twenty lived in a place of more than 2,500 population (Stegner 10). In recent years a discernable trend away from the cities and their suburbs toward rural areas has developed. A host of theories from recession, to ecology, to crime, have been postulated for this shift in the rate of growth (Kendall) (Beale). Whatever the causes, the likelihood is that the need for housing for the elderly may grow more rapidly in rural than in urban areas.

The federal and state governments have responded in a variety of ways to this network of problems. Within the U.S. Department of Agriculture, a rural credit agency, the Farmers Home Administration (FmHA), with over 1700 country offices across America, has a spectrum of housing programs specifically applicable to rural housing for the elderly.

The critical significance of the community context of dwelling units is adknowledged by the availability of FmHA loan funds for municipalities, counties, and special purpose districts seeking to develop or improve water, sewer and solid waste facilities, fire stations, libraries, health care institutions, community buildings, etc. Loans are made only when credit is not obtainable at reasonable rates from commercial or cooperative sources. Priority is given to communities of less than 5,000 people which seek to develop or to restore water and sewer systems. Loans are made at 5 percent interest for periods up to forty years.

The housing ideal of most Americans, ownership of a single family detached dwelling, is also the most prevalent housing form nationally and in rural areas. Appropriately, FmHA, under section 502, has loan funds to enable individuals, partnerships, or corporations to buy and to improve home sites and to build, improve, repair, or rehabilitate modest new or existing single family dwellings for family ownership. In order to qualify for such loans, borrowers must be: of low or moderate income; without decent, safe and sanitary housing; unable to obtain credit from private lenders on terms they can reasonably be expected to meet but have income adequate to pay mortgage, tax, maintenance, insurance and other costs of home ownership. FmHA will lend up to 100 percent of the appraised value of the site and the house for as long as 33 years.

The lack of improved home sites can effectively stymie construction. Because the cost of roads, water, sewer, etc. often makes development of individual house sites uneconomic, FmHA has, under section 524, loan funds to enable public or private non-profit organizations to buy larger unimproved tracts, develop them, and then sell individual sites to eligible applicants. Loan funds may be used for engineering and legal fees, and administrative expenses in addition to land and construction costs. These funds must be repaid within two years.

Large numbers of the rural elderly own their homes and either do not need, or cannot afford a new dwelling. Commercial credit is often unavailable to them for home repair or improvement. The FmHA has, under section 504, loan funds which may be used by such owners whose homes require *repair* to remove hazards to health or safety; or *improvement* to bring the structure up to the FmHA minimum property standards for new construction, or to remodel the kitchen, bathroom, etc. Households with adjusted incomes below $5,000 may borrow up to $2,500 for twenty years at one percent interest if the funds are to be used for repairs. Interest rates for home improvement loans range from 1 to 3 percent depending on adjusted family income. The maximum loan sum available for this purpose is $7,000 for a twenty five year term.

Rental is frequently an attractive and appropriate choice for the elderly. Where commercial credit on appropriate terms is unavailable, the FmHA, under section 515, has loan funds for individuals, profit and non-profit groups, and public agencies to construct, purchase of repair rental housing units which are modest in size and cost. The credit may be used for purchase and improvement of the housing site, development of streets, water and sewer services, recreational and laundry facilities. Borrowers must demonstrate competence to manage rental housing, and a series of safeguards to assure adequate long-term maintenance have been established.

Borrowers are also required to submit with the loan application: documentation of the need for rental housing in the area; a statement of anticipated income and expenses; and preliminary architectural plans, specifications, and cost estimates. The dwelling types for which credit is available include: detached, duplex, garden apartments, and moderate rise elevator units. However, nursing, special care, and other institutional housing types are not eligible for these funds. Loan periods for rental housing to be occupied by the elderly range up to fifty years. If the borrower is a non-profit or public agency, the loan sum may be up to 100 percent of the appraisal value or development cost, which ever is lower. For other borrowers the loan limit is 95 percent. In every case, the borrowers must limit occupancy in the rental housing to selected eligible tenants. For non-profit borrowers, depending on the size and income of the households served, the net interest on the FmHA loan may sometime be as low as 1 percent.

The range of FmHA responses to the housing needs of the rural elderly is quite broad, and although this review has done no more than hint at the characteristic administrative procedures and safeguards which government programs inevitably exhibit, the programs appear to offer significant opportunities for improved housing. A variety of circumstances have thus far severely limited their effectiveness.

The FmHA has not been adequately staffed. The agency's responsibilities have grown as a result of major legislation in 1972 and 1974, which significantly broadened the scope of its activities. Yet, the Department of Agriculture and the Office of Management and Budget have declined to add staff and budget funds to permit the programs to be effectively administered. One recent estimate, by the National Rural Housing Coalition, suggested that half again as many staff were needed by FmHA (Rural Housing 3). Understaffing of that order of magnitude will inevitably produce very serious problems, and it may be the issue which underlies other apparent disfunctions.

The West Virginia Housing Development Fund, in cooperation with that state's Commission on Aging, and FmHA recently conducted a year-long evaluation of the section 504 home repair and improvement loan program. The study was designed to reveal the constraints which were limiting effective utilization of the program; and to identify measures which would remove or mitigate those constraints, thereby making it more effective in meeting the needs of the elderly. Although the findings may not be characteristic of other FmHA programs in West Virginia, or of the operation of the 504 program in other states, anecdotal information volunteered by architects and others involved in rural housing in disparate parts of America suggest that the problems identified in the study are not unique.

Among the factors limiting the use of the 504 program in West Virginia were:

1. The denial of eligibility to families whose income and assets were within the limits prescribed by FmHA.
2. Unrealistically low income and asset limitations.
3. The establishment of an unrealistically low percentage of income which applicants could spend for housing.
4. The need to establish clear title to property.
5. The requirement that a mortgage be used to secure a loan.
6. Denial of eligibility because applicants lived near, but not in, areas FmHA did not serve.
7. Long delays encountered in loan processing.
8. Application forms inappropriately worded for their intended purpose.
9. An application process too complex for most families to complete without significant assistance.
10. Denial of loans without informing applicants of their right to appeal.

Ironically, the study revealed an inverse correlation between a county's income and housing needs, and the incidence of FmHA activity. By federal spending standards, section 504 is a modest program. Nationally its funding has been ten million dollars annually. Yet, in some years about half this sum has remained unspent: testimony to the significance of the problems which beset section 504 (Crosby).

Since 1975 the Department of Housing and Urban Development (HUD) has had, as its major housing program designed to directly aid low income households, the section 8, Housing Assistance Payments Program. Section 8 is often used in conjunction with the FmHA section 515 rental housing program. Under Section 8, subsidy payments are made directly to the landlord to bridge the difference between 15 to 25 percent of the tenant household's adjusted income and the HUD established fair market rent for the dwelling. HUD has established a structure of regulations treating design, construction, management, tenant mix, etc. for the Section 8 program. Many commentators have bemoaned the complexity of that structure, and some have suggested that its effect is to subvert the program.

Perhaps a more cogent criticism is that Section 8 is a rent subsidy program, and that most rural elderly live in single family housing which they own, and want to continue to. None-the-less, there is a need for rental housing. However, Section 8 operates only *after* the rental housing is in place, thus it is at best an indirect means for producing more housing. During periods of inflation and high interest rates, it is argued, programs are needed which can reduce the developer's costs in creating the dwelling unit.

By now you will have perceived that we are confronting the knotty debate over subsidy of people versus subsidy of buildings. Or, stated more emotionally: subsidy of needy families versus subsidy of fat-cat builders. Several years' study of this, and other classic controversies in housing subsidy policy, by the American Institute of Architects, resulted in the conclusion that our housing needs are so complex — and so pressing — that the nation requires not a single approach, but a rich mix of programs responding to specific subsets of the larger proglem (Fefferman). Prior to 1973, and the housing program moratorium imposed by President Nixon, HUD had a broad range of active housing subsidy programs serving a variety of needs. Today, only one program, Section 8, is in active use.

The decline in HUD housing programs has not been paralleled at the state level where housing finance agencies developed with rapidity during the 1970's. More than thirty states now have such agencies. Their size, powers, and accomplishments vary considerably, but most of their efforts have been focused on lending for low, moderate, and middle income families. Since these agencies are not for profit and the interest on the bonds they sell to raise capital is tax exempt, the interest rates on their loans are lower than is the case for commercial credit. Borrowers are required to pass these savings through to tenants in the form of lower rents (Tager 3). However, despite the high incidence of substandard housing in rural districts, the state housing finance agencies have focused their resources in other areas.

Conservative estimates indicate that one-fifth of elderly rural households are in substandard dwellings (Atchley 107). And, although the rural elderly do not receive even a fair share of the federal assistance now available; (Housing 6) clearly, no single change in these programs, and no single new program will adequately address the complex web of issues which give form to the problem of rural housing for the elderly. But little will be done unless the virtual invisibility of rural housing problems can be overcome. As McFarland and McGuire Thompson have observed:

> *In the city, suburb, and town, civic and charitable organizations, churches, minority groups, and community and neighborhood groups press for solutions to housing problems and contribute to their solutions with time, ideas, and money. No such organized concern has been mobilized in rural areas (McFarland 145).*

Organizations like the Western Gerontological Society must work in concert with such groups as the Rural Housing Alliance to help create an informed, active, and vocal citizenry to lead the federal and state legislatures, and their administrative agencies, toward an appreciation of these needs and more purposeful action.

Paper Presentation: "Retirement to the Small Town: Values Which Interpret Housing Needs" by Harold B. Freshley

In the geographically large Midwestern section of the United States, there is a large number of small towns which have relatively high proportions of the populations who are past the age of retirement. This paper will briefly describe the kinds of older people who currently live in smaller towns in the Midwest, some of the socio-cultural aspects common to small towns with large proportions of elderly, and some current research into what attracts older people *to* small towns and keeps them there. This background will provide a context for a discussion of some of the specific housing needs and housing attitudes of the small town elderly.

THE SMALL TOWN ELDERLY

The populations of most small towns in the Midwest are disproportionately old. Though the proportion of persons age 65 and over in the entire U.S. population is around 10%, the proportion in the smallest towns is approximately twice that. Some of the towns in Pihlblad's study had as many as one in three over the age of 65 (Pihlblad et al., 1976). This situation is primarily the result of technological change and industrialization. Those who live in the small towns comprise two main categories: *residual* residents and *in-migrants*. The residual residents of these communities are generally older because of the out-migration of young people—and according to Harootyan (1977), the ablest and brightest—who left to seek wider employment opportunities in the industries of the cities. Simultaneously the in-migrants are also characteristically older people.

The greatest number of in-migrants to the small town are local farmers or farmers' widows who moved in to the nearest town at retirement or when they could no longer engage in farming. They chose the small town because it was already familiar to them. It was "their town" where they had always brought their products to market, done their banking and, often, belonged to social and civic organizations such as a church or club. These local retired farmers and farm widows are characteristically of lower income and educational levels than their more urban counterparts (Pihlblad et. al., 1976). They have always been a part of the "community" but in their advancing years, they choose to live within easier access of local services—within the corporate limits.

Depending on the community, the second greatest number of small town residents are those who left in their youth, to pursue jobs and careers in larger cities, but returned to their hometowns to retire. In a study of retirement in Appalachia, Lozier and Althouse (1975) call these people "cash-ins." They may be attracted back to their home towns because of family property, desire to leave the city, or other family responsibilities. Nonetheless, their status in the community is not necessarily secure unless they are able to either reaffirm past claims or establish new ones.

Less frequent but growing is the number of persons from cities who have chosen to retire to a small town "...where they could live reasonably, pleasantly and cheaply (in what decent housing is available there)" (Butler, 1975: 116-117). Crime, pollution, congestion and the high cost of living in urban areas makes the rural small town look increasingly attractive to urban retirees. They are drawn to small towns because of a lower cost of living—particularly for housing, recreational opportunities, and because the pace, life-style and sense of community of the small town is appealing (Denman, 1976).

SMALL TOWN VALUES

Insider vs. Outsider

Although it seems almost presumptuous to attempt to describe the value system of the small town—as though there were not dramatic differences readily observable. Nonetheless, there are some generalizations which can be made which are useful in understanding at least some current issues for those persons who are "getting old" in small towns.

A caveat is in order at the start. The outsider's perspective of life in any habitat is qualitatively different from the insiders' or residents' perspective. The outsider cannot avoid a certain amount of cold objectivity which comes from viewing the community as one of many, in a wider perspective—relative to other communities. For the resident on the other hand, this relativity is less salient and the unique aspects of the community are more important. Thus there is a subtle gap between the viewpoint of the in-migrant, the sociologist or the planner who see the small town as a place where old people fare relatively ill or well—and the viewpoint of the older person who has always lived in the small town and who lacks this relative objectivity. This is an important distinction. Despite advances in transportation, the media, and other forms of communication, today's rural elderly are *not particularly aware* of their relative deprivation regarding housing, transportation and other services (Pihlblad et. al., 1976). For them, this is the way it is, always has been, and always shall be.

CONSERVATISM OF THE SMALL TOWN

For one thing, *all* the older members of today's small town population were born around the turn of the century and consequently acquired their system of social values and attitudes—their socialization—early in the twentieth century. During their developmental, or formative years, most were exposed to and acquire the values then prevalent in America's small towns, values which are somewhat different than those which prevail around them today. Some have "changed with the times", but the small town provides older people with something of a buffer against social and value change.

Most obviously, with small towns having large proportions of older people, there are greater numbers of persons who share the same attitudes and values. They are members of the same socio-historical cohort. Their greater concentration provides mutual support for values and attitudes.

And although small towns are changing—even rapidly—nonetheless they are on the tail end, rather than the vanguard of America's cultural upheaval. Galliher (1961) describes the tremendous changes brought about in "Plainville" as a result of three major developments: the New Deal, proliferation of communication and transportation technology, and the Second World War. Still, the major changes in attitudes, styles and values are spread *to* the small towns *from* urban areas via the media. And these changes are interpreted and modified to fit the socio-cultural realities of the small towns, and accepted only partially and usually over a longer period of time.

SMALL TOWN VALUES

C.T. Pihlblad has written extensively of the value system of the current small town elderly (especially chapter 2 in Pihlblad et. al., 1976) and has borrowed from many sources in an effort to piece together the underlying, least modified social values of today's elderly. Sources include works by anthropologists, historians and novelists as well as school textbooks, remeniscences, songs and autobiographies.

Among the values which emerge in this study are many which are still prevalent among older people in small towns. Given today's ever-increasing dependence on services and labor-saving devices, the extreme *self-reliance* of older people provides us a sharp contrast. And this is especially so because, with age, people become physically less able to do everything for themselves. But self-reliance was basic to the subsistence economy of the rural farmer at the turn of the century. Characteristics needed for survival in rural areas included hard work, ingenuity, and courage in the fact of insuperable adversity. Not only were these values preached to the youth, but they were admired and respected when practiced by others. As an orator for a travelling Chautauqua, Ralph Parlette delivered his famous speech on "The University of Hard Knocks" over 4,000 times (Atherton, 1954). The message was self-reliance, and the message was popular.

The opposite of this value might be described as dependence on others, putting an extra burden on those around you. Life was sufficiently tenuous that high rates of dependence could not be tolerated. Anyone who did not "pull his own share" felt the effects of negative social sanctions. Times were hard and there was little margin for anyone who did not contribute what he or she could. No one wanted to be considered lazy. You earned respect and security only through hard work: "Your due is earned by the sweat of the brow."

Consequently, there is also emphasis on frugality and modesty. Most everyone described themselves as "plain folks", and although social status differences obviously did exist, "to 'show off' or to try to make oneself out as better than ones neighbors was an unforgiveable offense" (Pihlblad, 1976:23). Ostentation and love of luxury were frowned on. Satisfaction was derived by fulfilling simple needs and it was not desirable to wish for more than the Lord saw fit to provide.

SMALL TOWN VALUES AND THE CASE OF HOUSING

Butler (1975) reports that two thirds of Americas' substandard housing is in rural areas. Older persons, and especially those in non-urban areas lack the funds as well as local resources for maintaining existing housing or creating new housing. Pihlblad (1976) reports that 81% of a large sample of small town elderly 73 years old and over owned the houses that they lived in and that the mean age of these dwellings was 48 years. Most had high ceilings and little or no insulation making them difficult and expensive to heat in winter.

Because of the age of the houses, many suffered general dilapidation: leaky roofs, sagging floors, cracks and bad plumbing were not uncommon. The constant maintenance required by these old houses was reported as both physically and economically difficult, and especially so for women.

But they were satisfied with these conditions? Overwhelmingly. Over 94% of the elderly sampled said that they were satisfied with their current housing. Increases in the number of household "conveniences" such as electricity, running water, televisions and telephones were noted. Since most of these persons were brought up and raised their own families without benefit of electric lights or indoor plumbing, many appreciated them as luxuries rather than necessities. For an even greater number, these "conveniences" have increased their ability to live independently. Gas heat and washing machines have cut down tremendously on the amount of physical labor needed for keeping warm and clean. Telephones and televisions have increased their sense of contact with their families and the rest of the community and nation. In general, older people in small towns do not want more than they have—but they resist having that taken away from them. They want to be self-reliant and take care of themselves in the spirit of "rugged individualism." They resist getting anything for nothing and disapprove of it in others. They want to live in their own homes as long as they can and they show courage and ingenuity in adapting to physical decline. For a great many, to move from their current housing conditions is synonymous with giving up.

WHAT OF THE FUTURE?

The current cohort of the rural elderly is strongly independent and self-reliant. They want to live independently in their own, old homes—and to have to give them up is to have flunked one of the tests of life. Although their homes may be in need of repair, their overall satisfaction with current housing is high. Relative to their own youth, current conditions offer little cause for complaint.

The current increase in in-migration of retirees into small towns—especially to the Ozarks of the Midwest and other areas which offer outdoor and recreational opportunities—may well signal a major change in small town values and attitudes especially toward housing. These persons are relatively more affluent than the life-long residents in the communities, they are less likely rural in their origin, and their expectations and demands for quality in housing are likely to be greater. At the same time, they do not have the same sentimental attachment to the past that the "old-timers" feel about places and houses. The relative objectivity of the in-migrants will create a demand for improved housing and new housing.

Future cohorts of elderly—those who have been brought up in an era of relative abundance, rapid change and easy mobility—may be very different from the current cohort. Rehabilitation of existing housing, though clearly most acceptable to today's small town elderly, may not be the choice of the future.

SECTION 202: HOW TO GET STARTED—PROCESSES AND PROCEDURES

Coordinator: William Lightbourne, Coordinator, Aging Program, Catholic Social Services, San Francisco, CA.

Resource Persons: Phil Montex, H.U.D., Region VIII, Denver, CO; W. Ted Schuett, Schuett & Co., Denver, CO.

Recorder: Jim Fujii, M.S.W., Program Coordinator, Area 4 Agency on Aging, Sacramento, CA.

Section 202 is a construction and mortgage loan program that allows less expensive housing than conventional housing, but more expensive than Section 236 housing. The tie-in with Section 8 (a rent reduction program) is what primarily accounts for the reduced cost to the tenant.

Section 8 is a rental assistance program, providing subsidies to qualifying low-income individuals; they would be required to pay a maximum of ¼ of their income for housing, the difference (between that figure and the actual rent) being subsidized by the Section 8 program.

The Section 202 program is open only to non-profit groups. Initial regulations were issued in 1975, and stipulated that the sponsoring organization be non-profit, have proven organizational ability, and target the program for an area of demonstrated need. New regs issued in January, 1977, stipulate that the sponsoring corporation have a site or at least an option. Upon funding by H.U.D., the sponsoring agency must set up a new corporation which would be held legally responsible for the project (these procedures would be handled on the Area Office level).

The new regulations (January issue) have been temporarily withdrawn, and by April of this year the old regs will be in use again; but H.U.D. will still be looking closely to see that site selection has been given close attention. January 31 regulations (see Federal Register), which are proposed regulations call for regionalizing the application process (to the Area Office level).

Application Process:

Around April 6, 1977, H.U.D. will release funds to be allocated within 60 days. Potential sponsors should call H.U.D. requesting notification of this release date. Within the 60-day period several actions must be taken.

Application forms should be sent in, the application being for the reservation of funds (for the proposed project). The following nine exhibits are included for completion by the applicant:

1. Background information on the sponsor.
2. Organizational legal structure of the sponsor.
3. Sponsor's intentions regarding development of special development corporation.
4. Description of this new corporation, delineation of sponsor's committment to this corporation, demonstration of capability of providing $10,000 seed money (can be in-kind).
5. Indication of any prior undertakings in housing.
6. Financial statements of sponsor; five-year back audit required.
7. Detail of any earlier defaults, legal actions against the sponsor.
8. Demonstrate ability to develop, own and manage housing.
9. Summary—including size of project, house sites, other physical descriptions, etc. (optional).

This request for fund reservations is done on FHA form 3128 EH.

This initial application process must not be pursued without touching base with local community groups residents for their support. If a locality is covered by a Housing Assistance Payment (HAP) contract, the proposed project must either be reflected in, or at least not conflict with, this Plan.

H.U.D. then reviews the request, and either approves, denies, or places the application on a contingency list. In any case this involves a several-month wait for the sponsors. If the application is approved, the sponsor is invited to the Area Office (with the other approved applicants) for a meeting.

The preliminary Section 8 Proposal will require the sponsor to have preliminary architectural renderings. The rent structure of the project must be explained, and the fair market rent established for the project area. This process, which involves another two months, requires activity primarily from the architect. In the Final Section 8 Proposal, detail of contracts, the management plan, and more detailed architectural work is required. The builders must have firm figures, and a complete breakdown of operational costs should be known. Finally, detailed architectural drawings must be submitted along with all information relevant to the housing program. The initial closing done, the loan is signed, and the money begins to flow.

Past selection indicates that only the large, established organizations such as the Salvation Army, Catholic Social Services, etc., which also have social service delivery capability get approved.

In the development team, the key individual is the consultant; he is particularly important as the selector of the architect, builder, and the development site. H.U.D. can serve as the consultant (Ted Schuett contends that in most regions H.U.D. lacks the capability to serve this role). The consultant is paid out of advance fees limited to $27,500; although 106B monies (non-interest bearing loans) can theoretically cover this initial expense, this section has not been functional to date.

The 202 direct loan program can also be used for substantial renovation and rehabilitation of existing housing.

Reference was made to a useful manual available at no cost to organizations (only): *Housing for the Elderly - A Funding Manual put out by the Area 4 Agency on Aging, 1832 Tribute Road, Sacramento, CA, 95815.*

Recorder: Mary Shenefield, Executive Secretary, Wyoming Senior Citizens, Inc., Riverton, WY.

Bill Lightbourne addressed sponsors from a sponsor's viewpoint and shared his application experience step by step. Section 202 is a direct mortgage loan available only to non-profit sponsors. What makes the money cheap is its connection to Section 8, the rent reduction program automatically tied to approval of Section 202. Section 106b, a non-interest-bearing loan for seed money, doesn't exist yet.

The first step in the process is a request for fund reservation (FHA Form 3128EH, July 1975). A series of exhibits follow the forms in the application. The first deals with the sponsor—

who, what, etc. The second deals with the organization and who has legal authority. Third is a statement as to who is going to be the development organization. An advantage of a Developing Corporation is that it is set apart from the sponsoring agency and thus the sponsor isn't open directly to potential suits. Fourth is the commitment of the sponsor to the new corporation. The legal minimum commitment is $10,000, which can be "in-kind." Revenue sharing can also be used, if made available. A description of the sponsor's previous experience follows. Sixth are the in-house capabilities of the sponsor including 5-10 years of audited books. Seventh is a statement regarding any defaults or any kind of legal action. The ability to develop, own, and manage housing is described next. The exhibits conclude with a summary.

potential sponsors must get community support because in cities receiving Community Development Block Grants, the HAP goals must be adhered to. In the next phase a letter from the mayor expressing his agreement as to zone and site is required.

HUD then reviews the application and sends letter of approval or disapproval. At this point architectural drawings are made available to HUD and the builder comes in with firm figures. A HUD market study is made and the rent structure developed. Congregate housing can use mini-kitchens, says HUD; they work with minimum property standards in their evaluation.

The firm commitment from HUD follows and at this point full architectural drawings and final specifications are produced. Initial closing and signing for the loan then occur.

Some cautions concluded the workshop's question and answer period. First, having a good consultant close in selection of site, architect, builder, and to help with HUD is good advice. Second, although HUD can act as consultant, few field offices have the concern or capability. Third, the needs and desires of the sponsor must be clearly communicated to the architect early. Consideration of costs must always be a factor (time is one of the costs).

Although fraught with frustration, the HUD 202 program is a good one. It is available and it can be utilized. With patience and the cooperative spirit of a good non-profit sponsor, housing for the elderly can become a reality under this program.

SECTION 202: SPECIAL PROBLEMS—LEGAL, FINANCING, AND MANAGEMENT

Coordinator: Robert B. Cummings, Pres., Robert B. Cummings and Assocs., Consultants in Management & Development - Housing for the Elderly, Huntington Beach, CA.

Resource Person: W. Ted Schuett, Housing Consultant, Schuett & Company, Denver, CO.

Recorder: Mary Shenefield, Executive Secretary, Wyoming Senior Citizens, Riverton.

Robert Cummings explained the three-fold aspect of 202: (1) Section 202 mortgage money at 6-⅞%; (2) Section 8 coupled with 202, a housing assistance payment to subsidize rent; (3) Section 106b a forgiveable loan of seed money for borrowing, preplanning, etc. (section 106b is still facing problems and hasn't materialized yet).

Constraints regarding the ability to obtain loan funds include the statutory limitations on the amount of money that can be borrowed and the ceiling amount based on fair market rent. Also mentioned was Section 231, an insured home loan for elderly housing, which is not utilized because of costs. The statutory limit under 231 is $24,030 per unit. Taking into consideration the special needs for the elderly for common space, extra money is needed. Practically speaking the $29,000 maximum allowable is inadequate. Since HUD is *not* in the business of refinancing, only *substantial* rehabilitation is financed.

The 3 step application process was briefly reviewed: (1) 202 Fund Reservation; (2) Preliminary Proposal to HUD relative to Section 8; (3) Finished cost including submission of architect's drawings, builder, etc., followed by initial closing. Each Regional HUD office has an elderly housing specialist, but area offices vary widely in the skill of their personnel. The restriction of ⅔ efficiency and ⅓ one bedroom has been lifted. HUD's limitations do require "bare-bones" building, however. Among the value that is allowed as "in-kind" is donated land. Upfront money is also allowable as "in-kind," but it must be tangible. Central feeding can be included in the design but only one meal per day can be mandatory. If congregate dining is considered, cost should be estimated in the application process. A schedule of meals could be drawn up by a nutritionist and the operational cost calculated by an in-plant food operator. Title VII can be used. Congregated housing with supportive services and environmental stimulation are positive factors to combat the loneliness and poor nutrition that cause the elderly to go downhill.

Section 202 is intended to provide independent living and congregate facilities. Section 8 is intended as housing assistance and applies *only* to dwelling, utilities, etc., *not* meals or services. Section 231 and 232 are insured loans, available for supervised living care (231) and intermediate care (232) facilities. A campus-type development could utilize all three programs.

Cummings then explained "hard" and "soft" management requirements of the completed facility. More than a landlord tenant relationship is required. "Hard" management refers to the fiscal and physical management (janitorial, maintenance, and fiscal responsibility of collecting rents and paying bills).

"Soft" management, on the other hand, deals with the care of the persons who are there to be housed. Since the purpose of the loan programs grew out of a concern for a persons' care, motivation for building housing units must include the "soft" aspect of management. "Soft" management is the sponsor's prime responsibility and should not be contracted whereas "hard" management can be contracted and enforced by the policy of the sponsor. HUD wants to know that for the 40-year life of the loan, care needs will be met.

Finally, Section 202 requires an affirmative fair marketing plan. The census in the building must reflect the total population differential and how this can be achieved must be identified in the application. Also, under Section 8 every applicant's declared income must be verified and the start-up expense allowed does include the cost of a resident manager to complete forms for potential residents.

EXPLORING USER CREATED ALTERNATIVE HOUSING ARRANGEMENTS

Facilitator: Jodi Cohn, Staff Assoc., Andrus Gerontology Ctr., Univ. of Southern California, Los Angeles.

Recorder: Janet Witkin, Director, Robert J. Green Contact Ctr., Temple Isaiah, Los Angeles, CA.

At the outset of the discussion, three groups were mentioned as underwriting the costs of alternative housing arrangements for seniors, having resident managers, and costing $250-$500 per month. Chicago's Council for the Jewish Elderly; Volunteers of America in Massachusetts; and a private corporation in Florida which converted old homes to accommodate 7-20 seniors per household.

Ms. Cohn was interested in finding out where older people had organized their own housing arrangements, without church base, without staff. For example, some seniors in Berkeley got together, had land and expertise; they wanted to put up cottages and a congregate space, with a light signal system (i.e. 1st light means "I'm okay, but don't want to see anyone." 2nd light means "Come on over." 3rd light means "I'm in trouble.")

One older couple in the discussion group is working with other retired professionals in Denver to establish a healthy environment for a living group: dining recreation facilities, a lot of natural green space (grass). They have architectural consultants, financial consultants, and an attorney working with them. They're talking about 150 units, starting with University of Denver retirees, expanding to their friends, but not open to the public at this time. They are trying to determine the basisof operation: condominium, cooperative, pre-paid life lease, or straight rental. Their site is 16 acres between the Swedish Medical Center and a residential area. They will set up a subsidiary corporation of the Swedish Medical Center, (a hospital more focused on health and preventative care than on illness) and Corona, their own group.

In Monterey, California, there is a group of professional people living in independent units, with certain congregate facilities.

One woman reported on a small group home for six seniors in an R-1 area in Lakewood, just outside of Denver. Each older person has a private room in the house. At first, the neighbors were scared and brought suit; they were afraid of having old people on the street, too many cars, etc. But their fears proved unfounded, and all is well now. A non-profit church group started this.

In Bellevue, Washington, a group of retired teachers are planning an apartment building. They've applied to HUD and are waiting for the go-ahead, are buying five acres, have an architect, are collecting memberships, and now have $28,000 to use. They will construct a three-story building with covered parking underneath; the units will be one and two bedroom apartments, straight rental; they'll hire a manager; meals will be prepared by a hired cook; each apartment will have a kitchenette.

A group in Los Angeles from the Robert J. Green Contact Center at Temple Isaiah and the Jewish community is interested in setting up a cooperative living situation for seniors, similar to the Charles Weinfeld Group Living Residence in Evanston, Illinois, developed and sponsored by Chicago's Council for Jewish Elderly. The Weinfeld residence serves 12 women, average age 82; the residents share six interconnected, adjacent townhouses and a variety of services in a warm, extended family atmosphere.

Catholic Social Service in San Francisco had thought it might work to move seniors in with other seniors who owned large homes, so all could share the costs. But, there was no way the homeowners wanted to do this; they wanted housekeepers, not housemates. However, Catholic Social Service got a much more positive response from renters when it was suggested that three seniors sub-lease a flat, thereby enabling them to live in a much nicer apartment together than each could possibly afford alone. The potential residents said they'd feel better about it if it were run by a parish; they also wanted the parish to provide furniture for the communal area. The Area Agency on Aging gave a small grant for this project and three parishes have agreed to each sponsor one such flat.

Also, the Jewish Welfare Federation in San Francisco has started a similar project on Cathedral Hill.

The Jewish Family Service of Baltimore has also set up a flat with several people sharing costs, including the cost of a housekeeper.

The April 19, 1976 issue of *Newsweek* contains the article, "Old Folks Communes" (pp. 98-99).

LEISURE SERVICES AS LIFE SUPPORT SYSTEMS

LEISURE SERVICES IN ALTERNATIVE SETTINGS: DAY CARE CENTERS, RESIDENTIAL CARE HOMES

Coordinator: Jean Trimble, Coord., Adaptive Geriatric Education, De Anza College, Cupertino, CA.

Resource Persons: Evelyn Gillet, M.S.W., Admin., Sr. Day Ctr., Palo Alto, CA; John Gray, Pres., Retirement Inns, Inc., Costa Mesa, CA; Scott Heffner, Instructor, Susan Whitamis, Teaching Asst., and Timothy Dunkin, Teaching Asst., Adaptive Geriatric Education, De Anza College, Cupertino, CA.

Recorder: Christine Stumpf, Student, Univ. of Southern California, Los Angeles.

PALO ALTO DAY CARE CENTER serves the fragile and handicapped elderly. Their goals are to rehabilitate, maintain what health factors they have, facilitate socialization and in addition, to give respite to the families.

The Center provides door-to-door transportation. The enrollees choose a 3-day or 5-day week and pay from $2 to $15 per day, according to their means. The actual costs per person are $23 per day and so it is necessary to solicit funds from private foundations and individuals. They operate in a rent-free facility.

Personnel includes the following: Psychiatric Social Worker, Nurse, (these two act as program directors) a Male Program Assistant, an Administrator, a Financial Administrator, a Driver and a Cook. Each staff member is multi-talented and does more than one job. The Center works on a consulting basis with a physician, a nurse, a physical therapist and an occupational therapist.

The day's activities include some of the following: gardening (herbal teas), ecology, naturalist classes (flora and fauna of surrounding area), current events, ceramics, needlecraft, threadcraft, arts, crafts, daily exercise (meditation as well as Sitting Down Soccer), music appreciation (incorporating body movements, playing of instruments and music therapy), nutrition (gourmet cooking). These classes are sometimes taught by specialists who are brought in as the need arises...and in many cases are people having teaching degrees, but no permanent employment. Also, the Center relys on community volunteers to involve enrollees in various community projects. Entry requirements are (1) Evelyn Gillet, Admin., does a home assessment, (2) there is a testing period of two weeks, (3) once accepted there is a psychiatric evaluation and medical evaluation which help determine the personal goals to be met, as well as a program for both home and Center to implement...thereafter there is a monthly evaluation. There really are no "graduates", since most stay with the Center. A nine page bibliography on Day Care Centers was provided to attendees.

ADULT EDUCATION - GERIATRIC STYLE.....or DE ANZA COLLEGE ADAPTIVE GERIATRIC PROGRAM

The administrators of De Anza believe that life-long learning is the job of community colleges, and so decided to extend it to the people in the nursing homes in their community. As the instructors first started, they found that they had to adjust and adapt the classes around Shower Schedules and Meal Schedules and lengthen the class time, but the classes were heartily welcomed by the residents. The nursing home personnel noticed a marked level of alertness after the classes had begun. They started with 3 instructors and 6 teaching assistants (out of work teachers) and grew to 12 teachers and 24 assistants.

Classes offered were: expressive arts, poetry, drama (psychodrama), writing, dancing, singing, current events, health (learn how their bodies work), instrument playing, exercise (including sit-down soccer). To make it more appealing to the prospective student, the class names were changed. They also put the classes on a credit/non-credit basis. Also offered were "excursions" of a days duration, in vans.

Students unable to meet with groups are met individually.

Values to the patients were several: they were more vocal as to their needs...there was an improved quality of life...there was a greater feeling of physical well being...it gave them mental exercise...there was opportunity and stimulation for socializing.

INTERGENERATIONAL PROGRAMMING OF LEISURE SERVICES

Coordinator: Pauline P. Gross, Graduate Student, Dept. of Recreation and Leisure Studies, San Jose State Univ., CA.

Resource Persons: Abbey Goss, Project Director, The Elvirita Lewis Foundation for Geriatric Health and Nutrition, Santa Cruz, CA.; Bill Peterson, Director, A. B. Hirschfield Community Center, Dept. of Parks and Recreation, Denver, CO.

Recorder: Roberta V. Ebert, Senior Citizen Coordinator, Dept. of Parks and Recreation, Corvallis, OR.

Pauline Gross presented the pros and cons of utilizing intergenerational programming. Professionals need to sensitize younger people to the problems of aging. It is the professionals' job to identify problems and then to invite the participants to provide solutions. The program was concluded with the caution of not trying to provide just intergenerational programming, but to offer a variety of activities the senior can choose from. Many federal guidelines have restrictions on age and the elderly may just prefer to be with others of their age group.

Abbey Goss presented an intergenerational child care center program that is being implemented in one area in California. Funding for this project is from three sources: 1) The Elvirita Lewis Foundation (private funds), 2) State Child Care monies, and 3) public school funds. This four room school was built on land next to a grade school. It was designed for both adult and child use by scaling equipment and work areas for both adults and children. It has a kitchen, a staff room, an office, and a play yard. The children are from single parent families. The grandparents are hired as staff and aides. The grandparents are chosen by their desire to work with children, with special consideration given to 1) consistency, 2) flexible work hours, and 3) income. Future plans include total community involvement.

Bill Peterson changed from working with children to working with senior citizens in one weekend. The Parks and Recreation department staff coordinate the recreation facility of a 250 unit high rise senior citizen housing development. While most such units have become isolated from the rest of the community, this unit has evolved into a community resource. It serves as a voting location, a PTA meeting place, and provides special service groups a place to adopt a grandparent. Because seniors communicate a fear of strangers, the facility is used only by groups that do not require supervision. There is a city park across from this facility. Programming for this area is segregated by sex rather than by age. This provides community involvement for people with a special interest such as tennis.

LEISURE SERVICES THROUGH OUTREACH: MOBILE CENTERS AND HOME CARE

Coordinator: John Hunt, Dir. of Recreation and Parks, City of San Pablo, CA.

Resource Person: Anita Magafas, Asst. Prof. of Recreation and Gerontology, Univ. of No. Colorado, Greeley.

Recorder: Marcy Stanley, Student, San Jose State University, CA.

Anita Magafas:

Outreach to Rural Areas, Rochester, Minnesota. This program began in 1966, and was initially funded by a Title IV Grant (Demonstration Grant) to determine if a central coordinating center could be established with satellite facilities in outlying areas. The center was located in Park Towers, Rochester.

The basic programs are recreational rather than multi-service, but Meals-on-Wheels under Title VII is offered.

All satellite groups meet in facilities on a no rent basis (i.e. bank, church, school, community hall).

At first six communities were involved; now there are five because one community is now functioning under another county.

Membership figures and attendence: 1966 - average at each of six centers was 193 members; attendence 2,123; 1977 - average at each of six centers was 433 members; attendence 9, 309. Meetings were weekly in the beginning but now members and guests meet twice each week.

Funding:

1. County - The County commissioner pays modest salary to director of each center, who is a senior citizen.
2. Dollar a year membership per citizen which goes to central office to print and mail newsletter and disseminate all information to satellite centers.
3. Fund raising by center members, i.e., one center paid off mortgage on house for center meetings with potlucks, fashion shows, etc.

Park Tower in Rochester is consultant and clearing house for all other centers. Every member carries a little card with information of all centers and their addresses and meeting dates listed.

John Hunt:

Omnibus Two - Mobile Senior Center in San Pablo, CA.

San Pablo is a community of 23,000 in the center of the San Francisco Bay Area. A survey was conducted, on a door-to-door basis, to determine why seniors were not taking advantage of senior citizen activities.

1. Fear of going out on streets and leaving homes (low income community and high crime rate).
2. Lack of transportation.

In the beginning, Omnibus Two was displayed at shopping plazas, etc. with brochures given out explaining programs and services, meeting dates, etc. Newspapers gave the "Big Blue Bus" much publicity. The vehicle is forty-two feet in length.

Costs: Purchase price — $2500.00
Renovation - $5000.00

The total price was $7500.00 (this is compared to the cost of a fixed facility, which is approximately $150,000.00). The cost of gasoline and maintenance is $.03 daily. Senior volunteers operate and maintain the bus. They also reupholster the seats, repair carpets, cabinets, and drive the bus. There is a recreational leader, paid $4.00 an hour, and he is also assisted by senior volunteers in implementing the programs and services.

The bus goes to ten locations each week; one location in the morning and another in the afternoon. It is not in operation on the weekends.

The bus meets at the following places: convalescent homes, mobile home parks and trailer courts, senior citizen apartment house complexes, private homes and is also used for street and block parties.

Permission is obtained at the site of the meeting place, whether it is public or private home or mobile park, etc., for plugging into electrical outlets and use of rest rooms.

The programs the bus offers are as follows: arts and crafts, Contra Costa County rotating library, seasonal parties, potlucks, dances and bingo games.

The services are as follows:

RSVP - director and volunteers

Social Security Information

Health - blood pressure and glaucoma screening

Discount cards - every merchant in San Pablo was contacted and approximately 83% responded and participate in a program extending discounts to senior citizens.

Rehabilitation of some individuals is taking place; several instances of seniors deciding to get out of beds in convalescent homes and out of wheel chairs to get out and up on the bus have occurred.

Auxiliary Services: "Mother Hubbard's Cupboard" located in an old motel building and containing food and clothing. Local women's club provides these without charge and a local cleaner launders the clothing. A small slip of paper is put into each parcel picked up by senior recipients which reads, "We hope you enjoyed shopping at Mother Hubbard's Cupboard and that someday you will be in better circumstances and may contribute to her cupboard."

There are two other vehicles, Omnibus One and Three. These are used to transport food, supplies and people to Omnibus Two. These small vans sometimes do limited grocery shopping for incapacitated seniors.

There is no charge for programs and services to senior citizens. A Saturday night dance at an elementary school ($1.00, approximately 125 people) donates the profits.

As far as the future is concerned, there are two applications pending for additional bus programs: (1) for pre-schoolers; 2) for teen-age programs.

LEISURE SERVICES THROUGH SENIOR CENTERS

Coordinator: William Pothier, Exec. Dir., San Francisco Senior Ctr., CA.

Resource Persons: Lillian T. Bell, Dir., Downtown Senior Ctr., San Francisco, CA; Frances Bozeman, Dir., Gaylord Senior Ctr., Denver, CO; Rosalie Gilford, Ph.D., Asst. Prof., Dept. of Sociology, Calif. State Univ., Fullerton; Cuma Smith, Dir., Celeste Campbell Senior Ctr., Eugene, OR; Robert K. Ward, Ph.D., Planner, Div. on Aging, State of Utah, Salt Lake City.

Recorder: Jane Gozzi, Student, Leonard Davis School of Gerontology, Univ. of So. Calif., Los Angeles.

The purpose of this session was to present a diverse selection of techniques and approaches for providing services to older people in the senior center setting. This workshop succeeded in several respects. It offered a variety of program presentations and illustrations of several techniques which are successful when used by caring professionals.

Bill Pothier told of a recent study which could provide important statistics showing the practicality of providing comprehensive programming for older persons in multi-purpose centers. This study could be used to back up reports or grant proposals to funding agencies.

Bill pointed out that rural programs tend to identify themselves as multi-purpose centers while urban centers are identified as clubs. His study found that nutritional programs attracted the largest number of participants, followed by information and referral programs, and then sedentary recreational programs. The study found that senior center programs cost an average of $89 per person served per year. This amount covers comprehensive programming with many health services provided. This expense is far below that for hospital or nursing homes.

Dr. Robert K. Ward presented the results of a study made in Utah, 1973-1975. Of over 31,000 older adults who were interviewed, almost 13,000 responded to the Choice of Center Activity part of the questionnaire. From these responses, a study was made to determine the relationship of housing, health, income and transportation factors to the leisure activities of the respondents.

Dr. Ward expressed the concern that too often programs are designed or developed out of desires of current participants at centers and are not developed as a result of outreach surveys or attempts to include the desires of the unserved people.

Rosalie Gilford covered loneliness and loss, multi-service centers and peer-counseling training programs, and the implications of the inter-relationships of these three subjects for the center staff. She cited a survey done by Robert Weiss on isolation and loneliness. Social isolation was defined as a loss of the social network such as family and friends. Emotional isolation was defined as the loss of an important other person. However, loneliness did not necessarily follow or accompany isolation.

Dr. Gilford discussed the philosophy of the multi-purpose centers and their services and outreach. She had worked until recently as the Director of the United Way Multi-Service

Center in Los Angeles, CA, one of ten demonstration programs in the city of Los Angeles. Her center used volunteer center participants as peer-counselors. They were trained in a program developed with the local community college.

Lillian Bell, Director of the Downtown Senior Center, San Francisco, CA (and co-worker with Bill Pothier), could only begin to touch on the complexity of the problems surmounted in making a success of their programs. Ms. Bell felt that outreach methods can be used inside the center building as well as outside. She felt that the relationships people formed at the center were the most important service to be offered.

Cuma Smith spoke of creative programming in a recreational setting. In her center in Eugene, OR, special men's programs, i.e. woodwork, were instituted to attract and serve more men. Ms. Smith talked about several special events held at her center: a community cooperative produce market, bicycle use and repair, a senior adult camping program, and a style show sponsored by a local dept. store to assist in clothing selection.

Frances Bozeman represented the Denver senior citizen programs where "their multi-purpose is in meeting the multi-needs of senior citizens." Programs to bring older people and their activities to a greater visibility by the general public were prominent. Senior Awareness Day was held in a shopping center, a Miss Senior Denver Pagaent is held annually, an annual picnic and Christmas party are given free and senior entertainment groups perform in nursing homes. They also have a "Meet and Eat Program" where 30 seniors meet at a restaurant which allows them to sit together, order what they want and pay on separate checks.

LAW AND THE ELDERLY—ISSUES, PROGRAMS AND SERVICES

PUBLIC POLICY AND THE LEGAL SYSTEM

Coordinator: Howard Gelt, Asst. to Governor, Governor's Office, Denver, CO.

Resource Persons: David Foote, Governor's Staff, Human Services Policy Council, Denver, CO; Dennis Gallagher, Colorado State Senator; Paul Nathanson, Esq., Exec. Dir., Senior Citizens Law Center, Los Angeles, CA; Eric Pfeiffer, Dir., Davis Institute on Aging, Denver, CO

Recorder: Marcy Stanley, Student, San Jose State Univ., CA.

Dr. Eric Pfeiffer spoke first and related his material to the area of: Mental Health Problems and the Elderly - and - How We Provide These Services to the Elderly.

Dr. Pfeiffer stated that this general subject goes back to the original Medicare Laws and the White House Conference on Aging of 1971. At that time there was a recommendation for a Commission on Mental Health by Senator Muskie. Subsequently the Health Revenue Sharing Act of 1975 was twice vetoed by the President. Then it was accepted by the President; and the Eagleton and Rogers Committee of nine members was appointed. It was to become effective July 29, 1975, but before the committee members were appointed, it expired. Senator Muskie was successful in having it extended. The assumption was that Mental Health for the Elderly fell between two chairs: Area Agency on Aging and National Mental Health. There were four major emphases:

1. Services To Identified Elderly
2. Preventive Services
3. Training of Appropriate Personnel
4. Services to Ethnic Minorities

Recommendations to be considered under National Health Insurance were:

1. Services to Identified Elderly - Any mental health care must be handled the same as physical health care under National Health Insurance.
2. Mental Health Prevention Services must be provided in the same way as physical health prevention services.
3. Long Term Care Facilities rules must be established.
4. Separate sections must be provided to elderly whether or not the facility is public or private under PL 94-63.
5. Geriatric: assessment - assignment - functions. AAA's role to be considered.
6. Amendments made to Older Americans' Act regarding specialized mental health services and the AAA's role in them.
7. Requirement for race and ethnicity included no quotas, but only the reporting of numbers of each person treated to develop a data reporting system that crosses boundaries of services.

Dr. Pfeiffer concluded at this time by stating that we need to call on all segments of society, not just the professionals.

Paul Nathanson then spoke on definitions of Legal Process and legal systems. Mr. Nathanson said that Legal Process is defined differently for different people. He said that Legal Process doesn't necessarily mean going to court, even though people have found out that agencies *can* be challenged regarding guardianship and involuntary commitment. He said that we must appreciate a broader understanding of Legal Process:

1. Lawsuit
2. Legislative hearing
3. Drafting of legislation
4. Legislative advocacy

Mr. Nathanson said that we must consider all sides of an issue, i.e., the Senate Sub-committee Hearing on "Women and Social Security"; the case of Wiesenfeld, Main Plaintiff, who held that widowers have same rights as widows; Sex Discrimination and Social Security.

Mr. Nathanson stated that the entire community can become involved and interested in legislation and public policy and that he gave Senator Deukmejian a list of 300 construction workers who came out to testify (at risk of great bodily harm) at a pension plan reform hearing; then he worked with Javitts and Williams to draft a new pension plan law.

David Foote was the next speaker. He briefly mentioned that Dr. Pfeiffer had met with Ms. Rosalynn Carter on February 11 of this year regarding a projected President's Commission on Mental Health and Illness of the Elderly and that he, Mr. Foote, is waiting to see if a professional and technological program will be set up.

Mr. Foote went on to say that legislation and litigation are both important, and that in talking about legislation, we should strive for clear and down to earth language, i.e., using the term "aging" rather than saying "gerontology". He told us that there are two or three avenues now being used by concerned citizens to change legislation:

1. Budgeting Process
   Citizens should ascertain the time period when proposals are examined by legislators even though most states do not have an open door policy in government.
2. Persons involved in the Budgeting Process
   a. Agency generating information
   b. Agency reviewing information
   c. Budget Committee
3. Impact of programs on other programs if implemented and if discontinued.

David Foote said we need a handle on where dollars come from and where dollars are going and why. He said, "Don't isolate specific issues. Seniors will come and talk about one issue but will not relate it to other or larger issues. Put *your* individual issue into broader public policies and get broader, stronger input. There is a need to do homework on related issues to support your issue. For example, the issue of Health in Colorado involves four agencies: (1) Medicaid; (2) Department of Health; (3) Department of Social Services; (4) Nutrition Programs. In Colorado at least seven different agencies have at least one program for the aging. The proliferation and interchange among these programs is enormous."

He continued, "Most social services are now in the medical model mold. You have to be sick to get served. We need to change this philosophy because these services are provider driven, not consumer driven, i.e., we pay providers to provide services and evaluate his services, but we should pay the client for the services and evaluate how they feel about the services. When we have had categorical programs, we are inclined to hold on to what we have and not be open to change. The most important changes are at the state level and involve: (1) Going to block grants and (2) Area Agency grants."

QUESTIONS AND ANSWERS

Q: What percentage of programs in mental health in Colorado are preventive?

A: Unsure, but probably not more than five per cent; pressures on providers might bring change. (Foote)

Q: Why are so many young people talking for us? There is not enough opportunity to talk for ourselves.

A: Not enough elders will take enough time to research self-help methods. (Gelt)

Q: Why do the young people have all the jobs?

A: The system is pitting us against one another and this divides us. There is a major labor movement in favor of earlier retirement to provide more jobs. (Senator Gallagher).

A: Look at Social Security system and mandatory retirement; it developed in the thirties when life expectancy was shorter. (Gelt).

Q: What are the incentives for lawyers to become involved with human services and poverty, etc.?

A: There are no incentives. The publicly funded para-legal program is impeded by the bar itself. The bar won't allow low class clinics and prohibits advertising. Incentives could come by (1) group legal services; (2) ajudicative services. Legal processes need to be de-mystified. (Nathanson).

ADDITIONAL COMMENTS:

The whole idea of public policy now is that we are not going to allocate many resources to the elderly; there is no major reform regarding such. We are now at the point where we let the private sector provide most elderly services. We need to see a reallocation of resources to human services instead of to goods and production. (Gelt).

We should look at program evaluations and see if there exists a program to fulfill needs of people discharged from institutions before they are discharged; we should look at budgetary problems and be sure that the money saved from decreasing institutional care will go into community care for the discharged clients. (Unidentified participant in audience).

POLICE/ELDERLY VICTIMS: PERCEPTIONS AND INTERACTIONS

Coordinator: Marvin Ernst, Ph.D., Director of Research, Dallas Geriatric Research Institute, TX.

Resource Persons: Sandra Baca, Victim Service Advocate, Pima County Attorney's Office, Tucson, AZ; Sharon Baggett, M.A., Research Assoc., Dallas Geriatric Research Institute, TX; Charles C. McDonald, Research Assoc., Police Training Program, AARP, Washington, D.C.; Marlene Rifai, J.D., Ph.D., Research Director, Older American's Crime Prevention Research, Dept. of Public Safety, Multonomah County, Portland, OR.

Recorder: Betty L. McMeekin, M.S. Candidate in Aging, North Texas State University, Denton.

This workshop related to the elderly person as the victim of crime and what can be done to aid and reduce this victimization.

Many who work with the elderly, including the police, have no skilled knowledge, training, or education regarding the specific concerns and problems of the elderly. When police, taxi drivers, cashiers, pharmacists, etc. interact with the elderly, usually both parties are interacting in and under strained, stressful conditions.

The police training program of AARP-NRTA, on-going research, protective measures, and other programs in operation around the country were reviewed. Programs and examples of types of training programs ranging from the use of law enforcement officers to aging experts and from multi-methods and multi-media were given.

Besides the training of law enforcement personnel, efforts are being made through the use of trained older volunteers to train and education other elderly in the functions and methods of the police; how the aged can protect themselves and their property; how to report crimes; and how the attending individual can share his knowledge and handout material with those elderly too isolated, afraid, or disinterested to attend the training sessions.

The basic impact of the various training methods and programs is to increase law enforcement officers' understanding of the needs, actions, and reactions of the elderly; knowledge of and how to beneficially involve other agencies to reduce the time spent by police in social service-type work with the elderly; and through education, promote better understanding and interaction between the elderly and law enforcement personnel.

CONSUMER PROTECTION AND EDUCATION

Coordinator: Barbara Fisher, L.L.M., Asst. Attorney General, Tucson Attorney General's Office & Lecturer, Legal Problems of Elderly, Univ. of Arizona College of Law.

Resource Persons: Judy Berman, Admin. Asst., Consumer Affairs Division, Pima County Attorney's Office, Tucson, AZ; Norine Miover, Chief, Bureau on Aging, Phoenix, AZ.

Recorder: Roberta V. Ebert, Senior Citizen Coordinator, Dept. of Parks and Recreation, Corvallis, OR.

Many consumer problems were identified at this session. Norine Miover started with: 1) Life Care Contracts, an agreement between a retirement housing facility and a resident. In this contract, the person agrees to pay a flat fee upon entry and a monthly payment for the rest of his life. The housing facility agrees to provide shelter, food, and medical assistance when needed for the rest of the residents' life. Advantages of this agreement is that the cost of the nursing unit is less if the person is in the home when he becomes ill or in need of a nursing home. Two states identify problems in this arrangement, California and Arizona. They are in the process of providing legislation to set standards and to control regulations for these facilities. This group suggested 1) there be a graduated fee related to age and health of the resident entering the facility, 2) standards are needed for nutrition and fire and safety, 3) health care needs to be identified in relation to medicare coverage, 4) a person needs an option and a time pro-rated scale for changing his mind about staying in the facility, and 5) funeral arrangements need to be stated in the contract.

Judy Berman presented six consumer problems: 1) Economic and environment costs are more for an aerosol container than for the spray container because there is more of the product in the spray container and the spray product does not endanger the ozone layer of the atmosphere. 2) Smokers have the right to choose to smoke or not; if cancer warnings have been listed on the cigarette package. However, in terms of food taken into the body, the Food and Drug Administration takes over the decision making and takes the cancer producing item off the market. 3) She listed a number of packaged food products that are less expensive than the homemade item of the product. 4) Prescription drugs cost more than generic drugs. In some states a person can ask the pharmacist to change the doctor's prescription to a generic drug of equal value. 5) Project Portion Choice was started in 1974 to help cut rising food prices and to cut waste. The consumer has a choice of a 10oz., an 8oz., or a 6oz. piece of meat: six or four shrimp and he can state the number of chops he wishes. The relish plate is passed rather than being left on the table. It was found that people ordered what they could eat, there was less food waste, and that the people ordered a dessert.

Barbara Fisher introduced 1) Utility Life Lines rates of utility companies. For a minimum number of kilowatt hours the customer will be charged a minimum rate per month. The company also asks for the name of a person or agency to call if the consumer is unable to pay the utilities. Deposits are another problem that the elderly, living on a fixed income, need assistance with. 2) Land Fraud has been a problem of people buying retirement property sight unseen. The Land companies need to make easy to read contracts, and they need to trade unusable land for usable land. 3) Thrift companies are not always covered by federal bank insurance. A person using these companies needs to be aware of who the insuree is and that the company has more assets than liabilities. 4) Funerals are a consumer issue. Consumers need to be aware of the cost of each service and the total cost of a funeral.

OLD

by Phillip Kimble, Executive Director, Fresno Commission on Aging, CA.

Old? - Old? What is Old
You ask me Now
And I want to answer you
Somehow.

Some say that Old is
not "What" but "When"
and they try to figure
when it will begin!

To them, Old is a matter
of living a number of days
and slowing down a number of ways.

To them Old will come some
certain year
and they try to deny it
or they face it with fear.

To them Old is like climbing
a steep mountain grade
even though it's a journey
that has to be made
they'd rather forget it
and sit in the shade.

But the shade's just for resting
it's no place to stay,
spend a short time in it
then be on your way.

Being Old - Old isn't something that
you are forced to do
You can get back out in the sun and keep
climbing. It's all up to YOU!!

So there's no way of knowing
when "Old" will begin
It's not necessarily a matter
of a certain time or when;
Being Old is an option
we don't want to lose
at least the alternative - dying
we'd rather not choose
until we've climbed
on up the mountain
and had time to explore
the joy of just living
and giving a little bit more.

Old? Old? What is Old?
I still hear you say.
I admit I can't tell you
at least not today
But I hope you take time
to enjoy it
In your own way.

INSTITUTIONAL AND COMMUNITY HEALTH DELIVERY SYSTEMS

OLD DOGS, CHILDREN AND WATERMELON WINE

Coordinator: Carl H. Slater, M.D., Asst. Prof., Dept. of Preventive Medicine, Univ. of Colorado Medical Ctr., Denver.

Recorder: Patricia Grinager, Ph.D., School of Nursing, Univ. of Wisconsin, Milwaukee.

A note on the blackboard that it would be much more"healthy"to meet outside in a park two blocks south of the hotel sent participants of this session skooting for the park. There, in the warmth of the late afternoon sun, Dr. Carl Slater drew out from the participants a wide range of ideas as to just what health is. He didn't want "fancy text book or BS concepts." Rather, he encouraged a sharing of ideas in a "slow, leisurely, watermelon wine fashion." The group produced responses that could be classified into personal, physical, mental, spiritual, environmental, and/or integrational categories. He related the fifteen "being values"of Abraham Maslow's self-actualized persons to the broadest possible interpretations of true health. He passed out a number of handouts from his course on the concepts of health which he teaches at the University of Colorado Medical Center. These included selected questions from John W. Travis *Wellness Inventory* as well as two pages to fill out by way of looking at individual perceptions of health and disease states.

The name for this session came from a country music song made famous by Tom T. Hall. "Old dogs," Dr. Slater explained, "care about you even when you make mistakes." "God bless children when they're still too young to hate," he commented. "Watermelon wine? Well, even though none of us have ever had any, we can still talk about the mellowing effects of it and imagine how good it must taste."

A conscience-stricken ex-marine, whom alcohol had aged before his time, interrupted this session with an impromptu monologue on his too bloody memories of the last World War, his belief in God, and the teachings of Socrates. These latter words, "Find yourself. Know yourself. Be yourself" very well summarized our discussion in the sun.

The spirit that pervaded this session was extraordinarily candid, informative, and honest. Much of this was due to the relaxed, down-to-earth demeanor and conduct of the discussion leader.

COMMUNITY MENTAL HEALTH CENTERS

Coordinator: Etoile S. Holmes, M.S.W., Mental Health Consultant, DHEW, USPHS, Div. of Alcohol, Drug Abuse and Mental Health Services, Region IX, San Francisco, CA.

Resource Persons: Thelma Essex, Dir., Gerontology Services, Kings View Community Mental Health Ctr., Visalia, CA; Raymond Liedig, M.D., Exec. Dir., Dept. of Institutions, Denver, CO; Eric Pfeiffer, M.D., Dir. of Davis Institute, Denver, CO; Rhett Potter, A.C.S.W., Dir., Weber County Mental Health Center, Ogden, UT; F. Leon PoVey, M.S.W., Dir., Utah State Div. on Aging, Salt Lake City.

Recorder: Nancy M. Adams, Graduate Student, Health Education and Gerontology, Univ. of Utah, Salt Lake City.

Approximately fifty people enjoyed hearing from the six panel members discussing aspects of treating the elderly in mental health centers. It was the concensus of the panel that community mental health centers in *most* areas are derelict in addressing Public Law 94-63 mandating specialized programs for the elderly in mental health centers.

Thelma Essex suggested the following format to implement services: 1) Internal assessment - evaluate what is being done right now within the center, by whom, and the staff attitude toward serving the elderly, 2) external assessment - needs of catchment area, 3) assess resources for elderly already existing in the area, and 4) establish goals and objectives. It was pointed out that the elderly are particularly "turned-off" by mental health, and will be slow to visit the centers. Decentralizing, outreach and playing down mental health were suggested as ways to populate the programs.

Dr. Raymond Leidig stated that setting policy and implementing programs took *clout* and *passion* on the part of the administrator and the director. He emphasized the importance of having some older people on the staff and on the advisory council to represent and understand the senior's needs.

Dr. Eric Pfeiffer stated that most diseases of old age rapidly respond to "people" therapy (understanding) and certain drug interaction. The conditions were readily treatable and the results were rewarding.

Leon PoVey emphasized the importance of agency interaction. All the panel members felt that communication with and support from existing agencies lent strength to their own preventive and treatment programs for the elderly.

Rhett Potter felt that although monies are always a problem for any new program, funding could be found by digging, borrowing, consolidating, etc.-bits and pieces to make up an adequate budget. He felt that lack of commitment to a program was more hampering than lack of funding.

CREATIVE LIFE STYLES

MIDDLE AGE: WILL ANYTHING HELP?

Coordinator: Ruth Dunkle, M.S.W., M.S.S., Professor, School of Social Work, Center on Aging, San Diego State Univ., CA.

Resource Persons: Virginia Boyack, Proj. Director, Pre-Retirement Education Project, Andrus Gerontology Ctr., Univ. of Southern California, Los Angeles; Joan D. Jones, Ph.D., Director, Programs on Adult Development and Aging, Antioch College, Columbia, MD; Shirley Waskel, Cont. Education Assoc., Gerontology Program, Univ. of Nebraska, Omaha; Ruth B. Weg, Ph.D., Assoc. Prof., Leonard Davis School of Gerontology, Univ. of Southern California, Los Angeles.

Recorder: Roberta V. Ebert, Senior Citizen Coordinator, Dept. of Parks and Recreation, Corvallis, OR.

Ruth Dunkle started the meeting by presenting information on middle age. She said there is no agreement when middle age starts. Both men and women go through a change.

Middle aged people today are unique and different. They now have good health, a high energy level and half their life to live reported Ruth Weg. This group of middle aged people need to re-examine where they are now and where they are going. The men are at their peak in the work world. The women need support and encouragement. New coping mechanisms need to be developed for the role change and education opportunities. It is damaging for today's middle aged person to accept negative images of aging.

Decision-making is an important process in today's world. Virginia Boyack's classes in pre-retirement education provided her with over 2,000 people asking questions on careers, on relationships with others, and on use of time. These questions were the basis for a research study using a sample with a wide income range of $5,000 to over $200,000. Results showed concerns in a need for affection and in identifying worth and value of self. Little concern was expressed in the woman's changing role in society. People questioned that had higher education and higher income had a more positive response. The married woman's outlook was the least positive. Women are now asking "what am I going to be doing for the next 20 years." The men are saying, "why not do what you have been doing."

Shirley Waskel's research was of three classes in adult development. Results were that 46 percent felt they had grown as a person and 5 percent felt they had made no personal growth. The women see themselves at different levels of development with one-third to about one-half feeling they had made growth, and with about two-thirds feeling they had made some growth, and about 5 percent feeling they had not made any growth.

Joan Jones did an exploratory study of three mid-life student groups. The women were in 1) a community college, 2) in undergraduate credit class, and 3) in graduate level classes. Each student was asked questions on mid-life. There was a difference in motivation for taking the class, a difference in self-perception, difference in ability to perform, a difference in body image. The single women were concerned with career development; they were interested in taking care of themselves first and they had a positive image of themselves. The married women were not concerned with physical appearance or decline as the men were. The mid-life homosexual man had negative images of himself. He felt he was old at fifty in his sexual life and in his career. The widow was feeling bereavement. The reasons the students came to school were fear or as a means of reaching a goal.

WIDOWHOOD—GRIEF, PROBLEMS AND INTERVENTION TECHNIQUES

Coordinator: Hazel M. Foss, M.A., Dir., Widowed Services Program, Univ. of Oregon Ctr. for Gerontology, Eugene.

Resource Persons: Emily G. Samms, M.A., Counselor, Widowed Services Program, Univ. of Oregon Ctr. for Gerontology, Eugene; Saul Toobert, Ph.D., Prof. and Assoc. Dir., Counseling Ctr., Univ. of Oregon, Eugene.

Recorder: Charlane Bertsch, Student, Minot State College, Minot, ND.

Society does not prepare us for widowhood. The 12 million survivors in the United States were created from death. They were created in the length of time that one breath did not follow another. Personal grief can be shared by many, but the grieving process is experienced uniquely by the individual. The three stages of grief - shock, recoil, and recovery are experienced to different degrees, for varying lengths of time, in overlapping and sometime recurring stages.

Widowhood is a time of transition—from wife/ husband to widowhood to woman/man. The need for supportive systems during the metamorphosis is genuine and essential. The Widowed Services Program sponsored by the Oregon Center for Gerontology at the University of Oregon in Eugene is attempting and succeeding in providing a comprehensive support system for the widowed. Hazel Foss, the program director, and Emily Samms and Saul Toobert, both on the counseling staff, presented the objectives and services offered by the Widowed Services Program. The Program is dedicated to helping the individual cope with the immediate problems of widowhood and to develop an acceptance to survivorhood. The role playing in the small group session stimulated poignant discussion and gave this workshop a special qualtiy of intimacy.

THE INTIMATE GENERATION GAP: WHEN PARENTS GROW OLD

Coordinators: Vern L. Bengston, Ph.D., Prof. of Sociology and Judith Treas, Ph.D., Asst. Prof. of Sociology, Andrus Gerontology Ctr., USC, Los Angeles, CA.

Resource Person: Barbara Bright, Exec. Dir., Sr. Adult Services, San Diego, CA.

Recorder: Shirley Misty Martinson, Project Dirctor, Hot Springs County Sr. Citizens Ctr., Thermopolis, WY.

Traditionally, as people aged and could no longer function independently, it became the responsibility of the grown children to care for their parents—often taking them into their family home. This traditional arrangement has been challenged and tested by a changing society. The purpose of this workshop was to explore what social changes have affected the family support system for the elderly, to discover how these changes are perceived by all persons affected and to think through how adjustment and modification of the traditional roles might best facilitate supportive, happy and mutually beneficial life styles for the elderly and their offspring.

Judith Treas mentioned demographic changes and the changed and changing role of women in our society as two factors placing stress on the traditional model of care for the elderly. Because people live longer, there are more elderly parents in the population and they are older; often the "child" caring for an elderly parent is over 60 himself. With the number of children per family decreasing, there are fewer kin options for care available to the aged parent. Women, the traditional custodial caretakers, have, in recent years, moved into the job market and have more demands on their time. Therefore, they have less time to care for elderly parents.

Vern Bengston mentioned briefly one form of generation gap we feel — that of the young vs. the establishment. He then dealt extensively with the intimate generation gap which exists within a family. Looking first at perceptions of this gap, he presented the commonly held idea that with nuclear families the grandparents became very isolated. However, studies show that this is not the case. Most of the elderly feel exceptionally close to their families and have a lot of contact with them. The middle-aged children perceive somewhat less cohesive and warm relationships with their parents, but in turn see their relationships with their own grown children as close and warm.

Four issues or problems generally arise in the intimate generation gap. The autonomy vs. dependence issue is one that calls for adjustments in all family members. Teens seeking autonomy cause role changes in everyone. If an elderly parent must reverse this transition and move from autonomy to a dependent or semi-dependent role again, everyone must adjust. It is important that grandma or grandpa maintain as much independence as possible. The second issue is one of changing roles and expectations to which the aging person must adjust. Some of them may be: retirement, widowhood, in-law-hood, grandparenthood or great grandparenthood. The third issue is that of equitable exchange - the balance of giving and receiving including the question of who should take care of parents. The fourth issue is that of disruption vs. continuity. Death, life style changes, geographic mobility and divorce are disruptive elements in family lives. Better communication systems decrease the impact of geographic distances. Grandpa and grandma can be the one stable element for children in a divorce situation and a legacy of a family theme passed on are all forms of continuity in the family.

Barbara Bright counsels families who have an elderly person no longer able to care for him/herself. The family can be a constructive support system to that person by realistically looking at the situation with the help of an objective, supportive counselor and then selecting the best option available. All adult family members and their spouses and, at times, the elderly person himself should be invovled in the discussion and plan selection. The first step is *assessment*: what are the needs of the elderly and of the other family members?; from past history, how does the family perceive that the elderly person will react and cope?; what are current family relationshipsP; what are other concerns of the family unit? The next step is *interpretation*: help everyone understand needs and potential of the elderly; look at future possibilities—what will be the impact of each option on the lives of each family member (don't forget the needs of younger members)? The final step is *selection* of services that will be chosen to best meet the needs of the elderly and the other family members. When this process is worked through, everyone copes better with and feels better about the change that is made because it affirms the value and worth of the elderly and recognizes the suffering of the adult children.

STRESS AND COPING: THE DYNAMICS OF MAJOR LIFE TRANSITIONS

Coordinator: Loraine Cutler, Doctoral Candidate, Psychology Dept., Univ. of Calif., San Francisco.

Resource Persons: Viola G. Berton, M.A., Chairperson, Older Volunteer Proj., Andrus Gerontology Ctr., USC, Los Angeles, CA; Ruth E. Dunkle, Ph.D., Asst. Prof., School of Social Work, San Diego State Univ., CA; Carl Eisdorfer, Ph.D., M.D., Chairman, Dept. of Psychiatry & Behavioral Sciences, Univ. of Washington School of Medicine, Seattle; Renee Garfinkel, Ph.D., Columbia Graduate School of Journalism, New York City, NY; Sheryl Kunkle, Fellow, Human Develop-

ment Prog., Univ. of Calif. Medical Ctr., San Francisco; Kay Porter, Ph.D., Research & Evaluation Specialist, Oregon Ctr. for Gerontology, Univ. of Oregon, Eugene; Mary Quayhagen, Doctoral Candidate in Nursing, Univ. of Calif., San Francisco and Assoc. Prof., Univ. of Colorado School of Nursing, Denver; Thomas C. Timmreck, Ph.D., Asst. Prof. of Community Health, Texas Tech Univ., Lubbock.

Recorder: Roberta V. Ebert, Senior Citizen Coordinator, Dept. of Parks and Recreation, Corvallis, OR.

Loraine Cutler Introduced the program by stating the operation of this presentation.

Ruth Dunkle presented her research in identifying sex difference in coping, in life changes, in economics, in relocating, in marital status, and in death. Her research studies show that people react to these changes in relation to their sex, their past experiences, and their marital status.

Mary Quayhagen's research on stress and coping was done in three large metropolitan nursing homes, using 90 subjects between the ages of 73 to 98 years of age. (25 men and 65 women). All these people were mentally alert and able to stand long interview periods. All expressed hope that their stay in the institution would be short but, they were afraid they would be institutionalized for a long period of time. Measurements used were the Stress Events Questionnaire and a measure of impact on how frequent, how recent, and how often the person thought about the events causing stress. Also considered were the stresses of the person before entering the institution. The focus of the study was on interpersonal relations, altered self-image, economic and health changes. Results showed that the older persons in the sample tended to be lonely and withdrawn while the younger subjects in the sample tended to worry. Other responses were dependency, dissatisfaction and resentment.

Sheryl Kunkle's research dealt with women in American society and their role change after the children were gone from home. She used a longitudinal case study method of 45 white middle class women. Three classifications were used to identify the personalities: 1) The Working Woman had three sub-classifications: A) The Career woman was self-directed in her job; B) The Seekers were unemployed but seeking work; C) The Circumstance women were working for economic reasons but would rather be in the home. 2) The Homemakers were also divided into three subgroupings: A) Expansive women were active with no personal involvement in their activities and they had achieved no personal growth; B) Defeated women were depressed, undirected and helpless, and they had no turning point in their lives; C) The Domestic felt they were needed in the home; these women had no turning point in their lives and 70 per cent expressed some physical ailment. 3) The Community Activists were similar to the workers in receiving rewards from their work. They had a turning point in their lives. Results were that stress or a turning point can be good for the person, helping make that person better adjusted and more self-directed.

As a person ages, he faces more strain and, therefore, becomes crazier was the null hypothesis tested for Thomas Timmreck's research. Results were that a person does not get crazy as he ages. He used the Health Opinion Survey and the Schedule of Recent Events. His sample was from the largest industry in Utah, using a cross section of all employees. His finding was from a 75 per cent return of the questionnaire. There are three periods in a person's life that stress is greatest; at age 24, between the ages of 40 to 44, and over age 60. However the stress period was less between the ages of 30 to age 34. Women tended to develop more neurotic tendencies than men.

Peer group counseling was explained by Viola Berton. Peer counseling is used in the Andrus Gerontology Center to help release the potential of older volunteers by lessening stress and aid in coping for the elderly with problems. The counselor is a teaching assistant, educator to the community at large, and a discussion leader.

Kay Porter instructs Area Agency on Aging staff by using self-help skills for practical use. The enrollment of her classes is limited to 40 people. She uses a variety of teaching skills to involve the student in learning.

Carl Eisdorfer stated that all stress is not bad, some stress is good for personal development and growth. There is planned and unplanned stress; unplanned stress is due to timing. For example widowhood is more stressful at age 40 than at age 60. Retirement is an error in judgement; blue collar workers see retirement as an improvement in health. Crisis leads to 1) grief of loss, 2) a higher order of personality or to depression. It is the professionals job to guide. The best guides are those who have been over the road before. When the person in crisis is nearing a functional status, it is the professional's job to let him get well. This is done by tapering the time available for his use to 10 minutes by telephone, once a week. There is a need for the person to telephone at a certain time, and for the helper to be on time for the call. Unplanned crisis can be helped by training. A build-up of stresses leaves a person with a serious illness in eight out of ten times. The helper has to deal with where the person with the crisis is now by listening. They can tell you what is needed; you have the directions to share with them. There is a change of personality at middle age, women become more aggressive and men become more nurturant.

REMINISCENCE

Facilitators: Jeanne E. Bader, Doctoral Candidate, Univ. of Calif., San Francisco and Horace Browder, Deputy Director, San Francisco Commission on Aging, CA.

Resource Person: Marianne LoGerfo, M.S.W. Candidate, School of Social Work, Univ. of Washington, Seattle.

Recorder: Peg Hatfield, Director, Linn County Retired Senior Volunteer Program, Albany, OR.

Reminiscence was defined as thinking about the remote past, and it was called an important coping mechanism when dealing with the elderly. A chance for the aging individual to evaluate his life, to relate the positive memories, reminiscence is recognized as a necessary part of maintaining mental stability in the elderly ill or those facing death. Reminiscence, rather than a sign of deterioration, was described as an opportunity to review one's life, to be conscious of what has been achieved and what one is leaving behind - good or bad. A positive factor is that reminiscence allows service providers to see the patient as an individual and to administer to him as a distinct entity.

Let the patient talk although it is painful because it is more painful if they hold it in. Written or oral accounts of life events establish identity and provide healing therapy. As a diagnostic tool, the reminiscence reveals the patient's level of self-esteem and, therapeutically, reawakens dormant interests, abilities and mental functions.

Programs for the elderly have recognized the value of remembering and have encouraged participants to write or record history or special life events. Many collections of these stories are being published as money making projects.

LIFE STYLES OF RETIRED PROFESSORS

Facilitator: James A. Peterson, Ph.D.,.Prof. of Sociology, Univ. of Southern California, Los Angeles.

Recorder: Patricia Grinager, Ph.D., School of Nursing, Univ. of Wisconsin, Milwaukee.

More inspired than hampered by lack of funds for his research into the life styles of retired professors, Dr. James Peterson persisted in his study at the University of Southern California. He succeeded in part by training work-study students in interviewing techniques.

Fellow faculty members early indicated their support for the intent of the project. They were concerned about their own pre-retirement preparation. They had a natural interest in those who had preceeded them in retirement. They had also experienced some of the usual occasional dissatisfaction in their own relationship with the university.

Dr. Peterson began by asking the University for the names of those professors who should be included in his sample. He received a list of thirty-three names. He found another ninety. This discrepancy alone alerted him to the lack of communication probably existing between the institution and those who had spent their professional lifetimes working for it.

He made inquiries into the following areas: current incomes; housing; professional and work activities including relationships with the university; social, familial and religious relationships; leisure; state of health and the degree to which retired professors had planned for their retirement. He applied multiple regression analysis techniques so as to weight these different factors in relationship to each other.

The most negative results involved relationships with the university. "It would be nice if the institution would send me a Christmas card," one seventy-two year old retired professor lamented. Nearly half (46%) felt that they had been overlooked by the university since their retirement. They indicated a desire to continue relationships with the institution; to enjoy library and laboratory privileges; to participate in group health and insurance plans; to be members of the faculty senate; to be granted book store discounts and free parking; and tuition for college age progeny.

Recommendations that resulted from the research suggested that a full time executive secretary and a half-time executive director be budgeted for attending to the needs of retired faculty; that retired faculty be granted the privileges they asked for; and that some planning go into establishing a third or Emeritus University in which these people could continue to lead useful teaching and learning lives. The Ethel Percy Andrus Gerontology Center has already volunteered to give space for making this latter idea an actuality.

SURVIVAL KIT: INCOME AND EMPLOYMENT

RETIREMENT—GOLD WATCH OR FINANCIAL SECURITY?

Coordinator: Gary B. Marsh, Retirement Training Specialist, Rocky Mountain Gerontology Ctr., Univ. of Utah, Salt Lake City.

Resource Persons: Dr. Belle Bernstein, President, Communication Resources, Denver, CO; Otto Gruber, AARP Regional Coordinator, Western Action for Independent Maturity, Long Beach, CA; U. Vincent Manion, Ph.D., Assoc, Prof., Ctr. for Studies in Aging, North Texas State Univ., Denton.

Recorder: Edythe Pierson, State of New Mexico Commission on Aging, Santa Fe.

The financial plight of all retirees in America today is ballooning inflation and shrinking dollars. For many there is sudden anonymity, isolation, ill health, and reduced mobility. There are many who have had no access to retirement planning, financial or otherwise. There are special populations, such as the poor and near-poor, hourly, part-time, or "term" employees, and many of the self-employed who have had no access to even minimal financial planning. The poor continue to live out their lives in poverty. The near-poor are suddenly finding their life styles further reduced to an existence well beneath poverty levels. Hourly, part-time and short term or seasonal employees continue to live with their ups and downs, perhaps for the first time experiencing a modicum of security with SSI. Yet, however inadequate retirement income, retirees have more security than many workers. Retirees no longer live in fear of loosing their jobs and their monthly pay-checks. Financial security in retirement rests on a three-legged stool: 1) Social Security/SSI providing basic sustenance, 2) Private pensions, and 3) Developing personal savings and/or alternate sources of income.

Outstanding authorities in retirement planning education identified a number of problems in addition to inflation and the shrinking dollar. There is the spiralling, high cost of medical care. No good disease prevention program exists in this nation today. Retirement is the great unknown. Most people are "scared to death" of that inevitable day when retirement comes. For many there is apathy. People must want to look forward to living their future years. Usually more time is spent planning a vacation than planning a retirement. Yet, in retirement, they are planning for a full third of their years. Even when there *is* some degree of financial planning, there is no notion of the emotional impact of retirement, the "role change", or rolelessness" of retirement. The problem is motivating the individual to act. Also, financial security or insecurity can be a state of mind.

Among the practical solutions recommended were: 1) planning, alternative sources of income, second careers - "making hobbies pay", 2) life-span planning, 3) life-long learning, 4) individual counseling, 5) discussion groups preferably including spouses, and 6) measures to curb the high cost of health care. From discussion by the panel and contributions from workshop participants, there evolved some step-by-step suggestions for positive action by business, by educational institutions, by government agencies and by churches and civic groups of the community at large.

Pre-retirement planning by business was seen to be a three step process: 1) educating those responsible, 2) getting a commitment from top management, and 3) implementing the program (group discussion and individual counseling). Pre-retirement planning and retirement programs were said to be emerging as bargainable issues for unions. The influential Union of Retail Clerks (700,000 members) have a phase-in retirement planning program carried out by individual locals with follow-up at one, two, and three year intervals. This could prove to be a model for retirement planning as a bargainable issue in industry.

Educational institutions should integrate life-span planning and life-long learning into school systems from kindergarten up. Curricula should be developed for elementary and secondary schools. Community colleges have become more aware, but there remains the question of why programs aren't better implemented. Government agencies were considered to have a very real contribution in leadership and standard-setting roles.

A major government responsibility is curbing runaway costs of medical care. The State of New York was said to have undertaken a retirement planning program for 225,000 employees at $5.00 per person. Some considered the plight of the individual to be the individual's responsibility. Yet every society has responsibility for its aged. Government will not have to move into regulations if the various parts of society are responsible to the needs of the aging.

Vince Manion reviewed a 10 year history of pre-retirement education. Initial projects were funded by DHEW. Dr. Frances Scott helped to design new models at the University of Oregon. In 1972, Retirement Services Inc. was formed as a retirement planning consultant service. In a dynamic, changing field, several models have emerged.The organizational development model teaches administrators the value of pre-retirement training. A "Community Change" model has been developed to help identify areas in which churches, schools, community colleges and other community groups can do a better job and help them carry out pre-retirement planning education. Then there are "problem oriented" coping programs, but there are some problems and frustrations in providing "prescriptions" for retirement.

Belle Burnstein spoke from her experience of several years of pre-retirement education in industry. Ellen M. Shong, MSW with a recent Law Degree from the University of Arizona, spoke from her experience with Climax Molybdenum a Division of AMAX, Inc., Climax, Colorado. Lila Weir shared her interests in pre-retirement counseling and small discussion groups for employees of the Samsonite Corporation. Otto Gruber, Western Regional Coordinator, AIM (Aim for Independent Maturity), AARP/NRTA, described the strong membership program of AIM and the importance placed on "training the trainers" in the AIM pre-retirement planning program. Four teams of four are given a week's training utilizing AIM materials for an 8 session series of group discussion on meaningful use of time, retirement roles, housing, health and safety, financial planning, etc. A final ninth session was added on "Peace of Mind" in Vermont. AARP/NRTA also sponsors an "Institute for Lifetime Learning".

Whatever the pre-retirement educational model, workshop participants agreed the objective is to motivate employees to do something about planning their own lives, inspiring them to become "masters of their own destinies."

Where will pre-retirement planning education be in another ten years? We were challenged to ask WGS to take a position on pre-retirement planning education...to draft a resolution to present to the Western Gerontological Society. But, time on the Gold Watch was running out.

Workshop coordinator, Gary Marsh, had moderated a stimulating session. The session concluded: "Wisdom is knowing what to do; Skill is how to do it; Virtue is getting it done."

THE GENERATION AND EXPANSION OF INCOME

Coordinator: Gilbert C. Murphy, D.Min., A.C.S.W., Exec. Dir., SENIORS!, Denver, CO.

Resource Persons: Anita Rasmussen, Chairperson, Commission on Aging, Salvation Army, San Diego, CA.; Lu Svoboda, El Cajon Nutrition and Senior Services, El Cajon, CA.

Recorder: Margaret K. Hohu, C.R.N.A., Graduate Student, Gerontology, Univ. of No. Colorado, Greeley, CO.

For the past 15 years, the Salvation Army in the San Diego area has been developing programs for outreach into the neighborhoods, the city, and the county where the elderly reside, reported Anita Rasmussen. For many years the Salvation Army operated without any grant monies, other than nutrition money for their 3 nutrition sites. There is no grant money for any of their senior activity programs. These programs are self-supporting from within by generating income and internal ways and means of support.

The Salvation Army furnishes the building, custodial services, and utilities. For the senior activities, all the supplies and equipment are purchased through funds which have been generated through the activities within the senior club. This is done by various fundraising methods. There is a voluntary $2.00 a year membership fee. This fee is, of course, a method to bring in money, and it is also an incentive to the membership for special benefits as reduced prices for special lunches, dinners, trips, etc. Other methods used to generate money for the facility are passing a collection box for coffee or donations, or selling items such as candles, napkins, folding scissors, wallets, hammers that have various screwdrivers that fit into the handle, etc. These items are taken on consignment from wholesalers. These are a few of the items that a group can get on consignment and sell them for a profit. The companies have already charged a sales tax on these items, thereby eliminating the need of the seller to worry about this aspect of selling.

To augment income for the individual and the center, the following ideas were presented by Anita Rasmussen.

1. *Flea Market of Hobbies and Crafts.* Individuals set themselves up for business by putting up their own tables, price their own items and sell their own items. Profit made on these items is theirs to keep, and this helps to supplement their income. The Flea Market was conducted on a monthly basis until a problem arose with the Board of Equalization and Taxation. If this project is conducted on a regular basis, then the seller must add a sales tax to the item and remit their sales tax quarterly to the Board of Equalization and Taxation. This entailed a lot of red tape, and the Salvation Army regulations forbid this. Therefore, this monthly project was discontinued and is now conducted twice a year, without a license, and this still gives the individuals an opportunity to sell their items and add to their income.
2. *Bake Sales.* These sales are conducted during the Flea Market and bring in funds for the individual who want to sell baked goods, or to turn those funds into the operating expenses for the senior center.
3. *Shopping Centers.* There are many shopping centers in the San Diego area, and a generous community benefactor, who gives the senior discounts and does "nice things" for them, opens up a big shopping mall once a year for one to two days to the seniors where they can display and sell their arts and crafts.
4. *Hobby and Craft Day.* This is conducted in conjunction with the city recreation department. Again, the seniors can display anything they made and sell these items.
5. *Closet Sales.* Closets are cleaned out once or twice a year and the articles are brought to the center. Such items as clothing which are no longer being worn, or white elephants, or gifts given to individuals which have not been used.

When trips are planned for the seniors, the trip must pay for itself. Funds are not taken from the center since many who contribute to the center will never take a trip because of some form of disability.

For the past two years, the Salvation Army has sponsored a year-round camp for all age groups. There is a camping period every year for seniors. Sometimes this is the only occasion the seniors have for a vacation. The cost if $27.50, which includes everything. These trips should be scheduled and advertised well in advance to give seniors the opportunity to save enough money to participate.

The majority of people that Miss Rasmussen deals with are in the low-income bracket. Across the street from the center is located a retirement hotel where the residents get two meals a day—breakfast and supper. They receive small social security benefits plus SSI which pays for their room and board, which leaves them $25.00 for incidentals and lunch. Since there is no nutrition program at this center, these seniors ask if they can do "a couple of hours work so they can earn enough money to buy a bowl of soup because they are hungry." The center, without a nutrition program, furnishes soup, crackers or chicken pot pies to anyone who says he is hungry.

The center operates strictly on the use of volunteers and has only one paid employee. The center serves 1200 people a month with the assistance of 40-60 volunteers. Twelve of these volunteers are RSVP members and RSVP pays for their expenses. This, in a way, supplements their income. Because there is no nutrition program at the center, they are allowed a dollar for their lunch, and money is also given for their bus fare to and from the center.

Because of necessity, the center had to derive ways and means of generating income. Last year's budget, without external help, was $39,000. Of this, $21,000 was contributed by the seniors just by "in-kind raising of funds through improvising ways and means of doing it," remarked Miss Rasmussen. The center operates 5 days a week. Other services offered are information and referral, limited amount of health services, outreach of hospital visitations, legal services, memorials, counselings, etc. The center attempts to serve the total person by a well-balanced program of recreation, service, and activities.

Lu Svoboda stated that up to 3 years ago, there were no services rendered from the Salvation Army in the El Cajon area. In December, 1973, they were approached to open a nutrition site. The senior citizens "stormed" the El Cajon City Hall and were successfully able to obtain a building to house the nutrition program until July, 1975, when they moved into a new facility.

Programs can be done without funds, although it is easier with funds. A problem does arise if grant money is utilized—what happens when the grant runs out and cannot be refunded? Will the program be incorporated or does the program die? The older person usually suffers when the program comes to an end.

Mr. Murphy divided the process of the generation of income, for individuals and groups, into two sub-categories. First, the supplementary income. This includes the kinds of employment opportunities where people can be placed in private industries and public agencies, and where jobs can be secured in the open job market. These opportunities also include the Title IX programs of Senior Aides which transfers people to non-subsidized employment.

The stipend volunteer should be considered separately under the supplementary income category. These are the Foster Grandparents, Senior Companions, RSVP (no stipend, but reimbursement), and certain other programs in the community; these are basic ongoing supplementary income programs. Title VII programs can be included in this category.

It is important that people know of ways to supplement their income. It is not necessary that money be paid out as a form to supplement a person's income; there are other ways. Energy is an example. Gil Murphy believes that there will probably be a way of supplementary income for this perhaps in the form of fuel stamps, or in winterization programs, or in energy conservation kits that can be made available for senior citizens by using solar heat to heat their water, etc. These too are forms of supplementary income programs.

Second, the temporary income. These are the incomes that become necessary because of a temporary condition. It may be the need of dentures, or the need of taking a trip.

Mr. Murphy maintains that there is something more than can be sold in the arts and crafts than just the products. First, he suggests, that the beauty and the skills in making these products be sold. Experimentation is being conducted in Denver in the Lost Arts program. In a department store in downtown Denver, craftspeople were brought in to demonstrate their unique crafts such as sugar sculpture, ice sculpture, quilling, etc. These craftspeople were reimbursed to do this. Many people shopping in this store during Christmas time observed these people working at their crafts. The next step was to introduce these craftspeople to the universities and the colleges in the community and ask that they utilize the skills of these artisans as teachers. A few are now teaching their skills to university students and are being paid a small stipend.

Secondly, under temporary income, are special group services to the community. Mr. Murphy believes that services can be sold to the community as a whole by senior citizens. There are occasions for temporary income where a group of senior citizens can say to the city council, "We can put on your banquet for you." Or, they can say to the park department, "You cannot get enough employees to get these plants planted in the springtime so hire our senior citizens from our club to plant these plants and protect the beautification of the city." Mr. Murphy argues that if we use our brains we can sell our senior citizens as a club or a group. The money can be used for a group activity or activities, or the money can be divided among the workers. There are certain advantages to using seniors to purchase goods and to be reimbursed in goods because of the tax problem, but these can be worked out.

Gil Murphy stated that there are certain special services that produce temporary income that should be available to senior citizens. For example, product development as the Elder Crafts in Chicago. The sponsor of the center goes to a company and asks, "What could you sell that we can make? Give us the specifications and tell us exactly how you want us to make it." In Denver, a group of seniors are making Mother-Daughter apron outfits for the May D & F Company. Mr. Murphy advocates product development as the only way to go and not going your own way. Too many men are building birdhouses or doghouses and the market is flooded with these products. Therefore, decent product development is the answer. Talk to the marketing people in the department stores or in the grocery stores and see what kind of thing that mass production won't make that the seniors can make, stick a name to it that will make it look good, get it a decent package, put it on the shelf and Gil Murphy believes that money can be made that way.

Clubs and associations can become revenue-producing by dealing in specialties such as begonias, or goldfish, etc. Form a group or an association of people concerned or interested in a hobby and then produce some kind of a buying and selling sequence. The best example is the travel club. A lady will get 25 people together, she is the 26th person and she goes free. This is a development for her. Another example is, as Mr. Murphy explained, himself. He is a salt-water fish enthusiast. There are people with organizational ability in the community who can form a group of salt-water fish enthusiasts, buy and sell merchandise relative to salt-water fish and produce some income.

Another category is producing income through temporary jobs. Gil Murphy suggests that perhaps seniors may be utilized to answering telephones via a "touch-tone" system on a rotation basis, for a fee in their own homes. Suggestions of sitters for houses, pets (including fish), plants, etc., or yard attendants, etc. were made.

Old wallpaper from wallpaper books found in a wallpaper-paint store make attractive necklaces by cutting the wallpaper in small triangle pieces, roll the pieces using a hairpin or knitting needle, string them with beads, and sell them.

Lenses removed from cast-off eyeglasses make attractive broaches or bolo ties by cutting pictures from greeting cards to fit the lens, lacquer this, and attach a safety pin in the back. This is another saleable item.

Tuna fish cans were made into attractive pin cushions. These were taken to restaurants to be sold on consignment. They were placed with the candies, gum and cigars and were sold rapidly.

A fix-it shop or an exchange or trade program is another form of temporary income production by saving. If we think in terms of stretching incomes, we are moving into a positive direction.

INCOME INNOVATIONS

Coordinator: Lewis Wallach, Asst. Regional Commissioner, Supplemental Security Income, Social Security Admin., HEW, Region VIII, Denver, CO.

Resource Persons: Margaret Kelly, Social Affairs Officer, Social Development Div., United Nations, New York, NY; Malcolm Morrison, Ph.D., Research Analyst/Economist, Social Security Admin., Office of Research & Statistics, Baltimore, MD.

Paper Presentation: "Income for the Aged Through Flexible Retirement" by Malcolm H. Morrison.
These remarks represent the views of the author and do not represent or imply the views of the Social Security Administration.

The labor market is not structured to provide opportunities to older workers who are considered to have reached their potential. It perpetuates the assumptions that older people don't care whether they continue to work or not and that they generally look forward to retirement. The labor market also restricts job opportunities through discriminatory practices which push older workers out of the job market—obstensibly to make room for younger participants. These restrictions are aggravated by continuing unemployment which denies opportunities to older workers.

Forced retirement is not only economically damaging, but also has emotional and physical consequences. When people retire, they almost automatically lose their status in the community and they develop a sense of isolation in spite of increasing dependence on others. Studies have shown that the involuntarily retired person is susceptible to physical and emotional problems which directly affect his life expectancy. Society must pay the heavy financial burden of supporting people who are affected by these problems.

In approaching the specific problems of workers as they age, two major goals have emerged: The provision of adequate financial benefits for the support of persons who have retired from regular employment and the development of greater flexibility of choice for aging workers as to when to partially or fully retire from regular employment. These two objectives are not in conflict. It certainly appears the case that as retirement income benefit levels increase, the proportion of older workers who choose to retire also gradually increases, but a certain number of persons remain motivated to continue regular employment. Providing the opportunity to continue working is an important social and economic objective. Increasing the financial benefits for persons who choose or are "forced" to retire is also an important objective. These two objectives can and should be pursued simultaneously.

Increased opportunities to choose between work and leisure should be available to older workers. Public and private pension programs should allow for more flexible retirement from regular employment and should review current rules and regulations which greatly limit personal choice as the age of retirement.

Since 1900 there has been a continuing increase in the number and proportion of older persons in the United States. Projections indicate that these increases will continue and will be of major significance in the early and middle years of the 21st century. The substantial increase in the number and proportion of older persons in the population will undoubtedly necessitate changes in the ways and means of providing economic support to the retired and in the options provided to those who wish to continue some form of regualr employment. In considering the development of options for more flexible utilization of time for older persons, it is useful to appreciate the magnitude of the demographic changes which are in progress.

In 1900 there were only 3 million persons aged 65 and over in the United States representing 4 percent of a total population of 76 million persons. By 1940 the *number* of persons 65 or over had tripled to reach 9 million but this still represented only 5.4 percent of the total U.S. population of 132 million persons. By 1973, there were almost 22 million persons aged 65 or over representing about 10 percent of a total population of 220 million. Population projections indicate that the number of persons in the 65 and over age group will continue to increase reaching 30 million (or 11.5 percent of total population) in the year 2000 and rising dramatically to 51 million (or 17.3 percent of total population) by the year 2030.

Since 1957, the expected number of births per woman of child-bearing age has been declining. While the number of births has been declining, a significant improvement in life expectancy has taken place due primarily to declining infant and childhood mortality. A person born in 1920 could expect to live 54 years whereas a person born today can expect to live more than 71 years. In addition, moderate gains in life expectancy have occurred for the aged—at 65 years a person can now expect to live another 15 years and at 75 years a person can now expect another 9.5 years. Increases in life expectancy combined with recent low birth rates and high numbers of births during the years 1940-1960 are producing at gradual aging of the United States population. This change is particularly noticeable in the shifting *age composition* of the population.

In 1940 there were 77 million persons aged 20-64 (working age) and 9 million persons aged 65 or over a ration of 11.7 aged persons for every 100 persons of working age. In 1973, comparable figures were 118 million and 22 million for a ratio of 18.6 aged persons for every 100 persons of working age. This rate will be fairly stable through the year 2010 after which time the growth in the age 20-64 population comes to a halt while the number of people aged 65 and over increased dramatically from 33 million in 2010 to 51 million in 2030 which results in a ration of 3l people past age 65 for every 100 persons of working age.

Thus, if current low fertility and improvement in life expectancy continue we will experience significant increases in the number and proportion of persons aged 65 and over during the next fifty years. In addition, assuming the continuation of current trends, the active labor force will have to support a much larger retired population relative to its size than is the case at present.

In recent years the practice of abrupt retirement from regular employment has been subject to increasing criticism. The desirability and/or necessity of ending work precipitantly at a pre-determined age irrespective of individual work capacities, abilities and desires are now subject to serious question. *It is our view that mature and older workers should have increased opportunities for choice between leisure and work as they approach retirement. The creation of options for such flexibility reflects an appreciation of changes in working capacity with age and also recognized that older persons are often* reluctant to make sudden drastic changes in their styles of life.

It has been suggested that there exists a fairly general desire for individual flexibility of retirement age including both early and later retirement. In addition, suggestions have been made (1) that retirement should occur as a transitional process with workers being allowed to taper off regular work both before and after the so-called "usual" retirement age, (2) that the possibility of temporary retirement should be introduced, whereby a period of retirement might be followed by a return to work and (3) that regular full-time work beyond the "usual" retirement age be made a real option for older workers. What the above recommendations really argue for is the introduction of much greater flexibility into the retirement process. While such an objective is laudable in and of itself, its implementation is unfortunately somewhat problematic. For any new innovations in flexibility must be introduced into an environment heavily influenced by an interrelated set of factors: The provisions of current pension systems, the responses or workers to these provisions; and general economic conditions which affect the availability of employment and willingness of private and public organizatins to allow for various specific flexible innovations.

Basically, there are four major options for older workers—these are: early retirment from regular employment; retirement at the "regular" age as mandated by various pension systems; transitional retirment (gradual reduction of work, possibly both before and after retirement); and continuation of regular full-time employment beyond the "normal" retirement age.

As circumstances have developed, older persons really cannot exercise an entirely free choice of options as they approach retirement. The choices which can be made are influenced by the regulations of pension systems, the individual's own thoughts as to the best course of action (based on his income, his health, attitude and personal reuqirements), the state of the labor market, and employer and trade union policies and practices. There has been extensive interest in the employment of older workers and various manpower policies and programs have been recommended to encourage such employment. However, in many cases these approaches have not been based upon an analysis of (1) the provisions of pension systems (which might provide incentives or disincentives for flexibility); (2) the response of older workers to these provisions; (3) labor market constraints; or (4) constraints of business or trade union policies. The development of realistic proposals to encourage greater flexibility requires consideration of the above factors.

Certainly, constructive manpower policy views its major goal as that of providing opportunity for each individual to choose to utilize his or her ability productively in the national economy. Pension and personnel policies, regulations and rules which *encourage* the removal of individuals from the labor force certainly cannot be viewed as accomplishing the above goal. If current retirement programs are encouraging the development of idleness among an increasingly growing "young-old" population and are resulting in increasing economic hardship for such persons, this cannot be viewed as satisfactory.

Recently there has been a growing concern with the fiscal integrity of both the Social Security system and private pension programs. Earlier it was pointed out that the future shift in the age composition of the population will result in an increasing burden on the active labor force to support a larger number and proportion of older persons. The financial burden on workers could be significantly reduced through adopting policies which would encourage and allow people to remain in the labor force beyond the normally accepted retirement age. If even a reasonable proportion of future older workers continue regular employment, the long-range potential actuarial deficit in the social security program could be virtually eliminated.

There are a number of significant obstacles which frequently prevent older workers from retaining their jobs or securing new employment. Unfortunately, these problems are now facing more and more workers 45-65 years of age.

It is, of course, absolutely essential that deliberate discrimination in employment on the basis of age be eliminated to the greatest degree possible. Current legislation in this area could certainly be strengthened by removing the age 65 limitation in present law. However, often discrimination takes place through the personnel policies of various individual employers who fear declining work capacity and adaptability of older workers and utilize institutional policies and insurance rules to encourage or force older workers to leave their places of employment earlier than planned. It is necessary to persuade employers to treat older workers equitably with all other workers and to modify policies and insurance rules which discourage the employment of older workers. Such persuasion can only realistically occur through private business organizations and through governmental efforts to enforce age discrimination legislation.

It has been consistently observed that with conditions of high unemployment, older workers tend to be heavily affected and that once they lose their jobs it is extremely difficult for them to secure new employment. Since persistent high unemployment is continuing, it is quite important that steps be taken to assist older workers who are particularly vulnerable to losing their jobs. Two particularly helpful approaches to this problem would be: (1) specifically designed job retraining courses for older workers; and (2) actions by federal and state employment services to discourage employees from imposing age limits in hiring and to provide special job transfer, job re-design, and job development programs for older workers.

A third serious problem which hinders the mobility and employability of older workers results from provisions of private pension programs which vest benefits only after long years of service and do not provide for transferability (portability) of pension benefits between employers. The Employee Retirement Income Security Act of 1974, does protect the pension rights of workers through establishment of vesting standards, but does not encourage very early vesting and does not provide any encouragement for transferability of pension rights. With the exception of a few industry-wide pension programs (such as within the automobile industry), the principle of transferability of private pension rights has not been adopted in the United States.

In the next twenty-five years we certainly can expect some signigicant change in the emphasis on work-centered and leisure-centered values. Also, it is quite likely that significant experimentation with new patterns of work and leisure will take place during this time period. We are approaching this experimentation with very little information and data about the preferences of individuals and the potential feasibility and consequences of various proposals for change. There is a real need for further study of the entire area of new patterns for work, leisure and education. To affect a fundamental change it is necessary to make worklife flexibility a specific expressed goal of public policy and to establish some organizational structure which would be responsible for overseeing the development and implementation of this goal. Government should assume a leadership role in supporting and conducting the research needed to better understand how individuals currently view the distribution of their time between employment and the various uses of free-time, how these views change over time, what new options might be preferred and utilized, and how individuals could best be prepared to adjust to upcoming changes in time allocation.

As the potential social and economic consequences of an increasing retired population have become more prominent, various international organizations including the United Nations, the International Labor Organisation, and the Organization for Economic Cooperation and Development, have called for the development and adoption of new flexible retirement policies by governments and private industries. There seems to be a consensus developing that society needs to carry a lower burden of economically dependent older people and should find the means whereby the potential of this population can be utilized. In doing so freedom of choice should be extended, offering options among continuing to work, retirement, and gradual phasing out from employment. This consensus is reinforced by existing research which indicates that we have passed the time when our assessment of individual preferences concerning work and retirement hinged on simplistic questions about whether or not individuals wanted retirement. People adjust to whatever circumstances confront them. It is very difficult to assess underlying aspirations and potential actions of individuals if they were given greater choice. While individuals always have preferences, the options available limit the choices that can be made. Unless we begin to introduce more flexibility now, the options available to retirees will not be expanded, and current trends will continue unabated with the growing financial, social and psychological consequences of which we are all aware.

The response to the problem of increasing flexibility for older workers has been limited in both the United States and Europe. It is clear that at present, business corporations and unions have a minimal interest in the retention of older workers. Government, too, seems to have gone along with the tide in facilitating the early retirement trend. In my view, a major reason for the lack of development of flexible retirement (and flexible worklife) approaches is inertia and unwillingness to disturb the status quo. References to retention of older workers as blocking other workers are far less often heard than they were ten or twenty years ago. There is much more recognition that our problems with having a sufficient number of jobs relate more to economic growth than to trying to adjust labor market demand by penalizing one group in order to assist another. The trends of mandatory retirement and early retirement are beginning to result in adverse consequences which are quite costly and socially detrimental. Most people would not agree that it would be wiser to try to solve our labor force problems by continually requiring aging workers to leave employment at earlier and earlier ages so as to provide enough work for the remaining younger population who would then have the increased burden of supporting those not working. It is clear that certain other and probably novel economic adjustments are going to be needed to deal with labor force problems. New ways of arranging the worklife will be prominent among these innovations.

What we have in our country today is essentially a set of incentives which operate more or less in one direction and that is to encourage people to get out of the labor force when they get older - to get out as quickly as current retirement policies allow. We should all realize that current retirement policies and programs are not frozen in stone, they were devised and implemented in response to prior social and economic conditions, at which time the average length of life was considerably shorter than at present and when the financial burden of supporting a retired population was far less than it is today and will be tomorrow.

Under present circumstances it is extremely difficult to convince a whole society to change a complex series of interrelated policies. So the only other alternative becomes the actual development of different approaches with individual employers, with unions and perhaps other kinds of organizations, which can demonstrate the viability of different types of employment alternatives for older workers such as: job-shifting as people age and capacities change; increasing the availability of part-time work rather than job-termination;

and providing the opportunity for a person to take time off from work for a period of time without really retiring and then come back to work at a later point in time on some basis, whether full or part-time. These types of alternatives can only be adopted by corporations, governments and other organizations who are in actual positions to make them available. Along with demonstrating such approaches, we should begin consideration now of methods to revise public and private pension policies to make allowance for partial pension payments for persons wishing to continue employment at older ages.

Despite lack of major governmental, private industry, or union reform in the area of flexible retirement, certain approaches are being implemented both in this country and abroad which provide some models as to what might be done to provide more opportunities for older workers. In this country for example, the United States Steel Corporation and Walt Disney Corporation have abolished strict mandatory retirement rules and attempt to provide employment for older persons wishing to continue to work. Also, the Retail Clerks International Association is initiating a phased retirement program which allows for a gradual diminution of work in the final year of employment. Other examples could be cited. In Europe, a variety of "phasing-out" approaches are being utilized by corporations, especially in France, and in Sweden, new and even more sweeping reforms now encourage more flexible retirement through provision of partial pensions and replacement of lost earnings when older persons reduce their work schedules.

My study of the current and evolving situation of older workers in this country leads me to the following conclusions. First, the current early retirement trend is very pervasive and is likely to continue unabated removing more and more potentially productive citizens from the labor force at earlier and earlier ages through the year 2000 and beyond, unless we begin to develop and demonstrate alternatives now which can gradually be broadly adopted as new policies and programs of flexible retirement. Second, the current early retirement trend is supported and maintained by a complex set of interrelated retirement policies, programs and procedures which have evolved in response to social and economic circumstances of the past; these circumstances are now changing and forcing us to review the utility of our prior approaches. And third, we must begin to modify current retirement policies, programs and procedures now, if we expect to reduce the growing financial burden on younger workers and retain the productive capacity of a growing older population.

FLEXIBLE RETIREMENT PLANS

Facilitator: James R. Jones, Head, Community Services Division, United Planning Organization, Washington, D.C.

Recorder: Margaret K. Hohu, C.R.N.A., Graduate Student in Gerontology, Univ. of Northern Colorado, Greeley.

There have been many varied opinions during this conference about pre-retirement programs that are operating, the successes that have occurred, and the different approaches used. The purpose of this discussion was to be more global and, hopefully the outcome of some insights to an approach and a comprehensive strategy.

Everyone is aware of the demographic shift with the increase in the older adult population. Basically, this increase does not matter; however, we should consider the economic exchange factors that are going on in the country. A tremendous number of people, even in their thirties, are being supported by the parent group. On the other end of the spectrum, people are being encouraged to retire or to leave the mainstream of the work force earlier and earlier. Basically, this is only a temporary situation. However, there is a crunch on those who must retire now, or those who retired 5 years ago, because of the inflationary factor. What needs to be looked at is a broader range of activities and a whole new set of thinking and planning for social changes that need to occur now. Drucker indicated that one of the things that will happen in the 1980's is that manpower planning, which is already happening, will see the need to retain people in the work force until they are about 70 years old. That means for most corporations in the next 5-8 years, there must be complete re-training and restructuring within the organization. Normally, the corporation training stops for a person in their forties or fifties.

Five areas discussed recently at a international symposium in Belgium, sponsored by the International Labor Organization, dealt with approaches countries should take toward the older worker. Various countries had positions on this. The categories discussed were:

(1) What type of legislative outcomes need to occur to produce the legitimate legislative action to handle present inequities and to facilitate appropriate social context for changes in the future? Legislation is complicated because of the many layers.

(2) What is the process of public education? What is the outcome that should be there because of public education?

(3) What type of education and re-training programs need to occur to support the outcomes you desire?

(4) What type of other careers or opportunities for voluntarism should be available for the person who chooses to retire?

(5) What new roles could we define for older adults in society?

Presently, we have a manpower pool and within the next 5-10 years this manpower pool will grow and be better educated. The educational attainment of the older population is increasing yearly. What type of roles can we think of or plan for in our society for people who are different than in the way we have perceived of them in the past? What needs to happen in these 5 functional areas, and how do they relate? We will always have a growing society and a growing labor force. Flexible retirement means shifting societal roles.

What would it take to re-train an older worker for re-entrance into a new career? There may be many approaches. Sweden has a 2-sabbatical format sponsored by industry. The first sabbatical normally occurs in the thirties when it appears to be most advantageous to the individual and to the organization. This is a cooperative effort. The sabbatical is expected to increase the individual's proficiency in his technical field, in his trade, or in his profession. The first sabbatical gives the individual the opportunity to expand on where he is going. The adult worker works part-time and experiments with an alternative career to prepare him for retirement during the second sabbatical.

How are we going to educate the public that the older person is not obsolete? People must see some values in the older population. Studies have shown the economic feasibility of re-training and retaining the older adult. The European market has tremendous information which shows that the older adult is more reliable, can produce just as well, and is better in re-training because of past experiences, expertise and will quickly "catch on" to the new technology.

Many universities and colleges are granting degrees to older adults. Life experiences of the older adult are considered as part of the format, and may be used to upgrade one's profession, or used by those who have had no formal "job experiences", except for volunteer work. The older adult may use this "life experience" toward obtaining a degree. If a person can show that they can learn through life experiences, it is the best education one can have. However, one does lose a "liberal arts education" when one goes through this format, but we are dealing with a person who wants to become technically capable and able to perform in society. The housewife who has performed in the home, in the community, and in the schools, etc. has acquired a tremendous knowledge in life experiences and now seeks the opportunity to perform in the job market. Therefore, true education should be directed to the person's individual experiences and abilities.

Public education should also be addressed to the concept of leisure/free time to be able to accept this time as productive and not wasted. This includes the concept of re-training the individual, technical training, other careers, doing volunteer work, and what new roles the older adult might have. The role of the older adult in society needs to be re-defined. We must identify the roles of the older adult in the community and see that they get paid for doing the job.

Mechanization requires energy and there is an energy shortage. The trend to replace the older adult worker with the younger adult worker will not last because of the shift in the need for manpower during the energy crises. The only way that this trend can last is to have some major technological shifts where our society becomes almost automated and it is very obvious that the only way this could possibly happen is if we had an unlimited energy supply. Organizations, such as the American Organization of Training and Development, are dealing with re-training of their personnel at their professional capacity. For the last 2 years, they have been talking about what will happen in the 1980's when people will be working when they are in their 70's.

What else do we need to do at this stage to create an appropriate type of retirement? Russia has the attitude that there is a contribution that everyone can make. In America, this attitude is lacking: instead, the attitude is that a person can make a contribution if that contribution produces a dollar in the production-oriented marketplace. We should look and see what position is more appropriate to serve the ends of our society in the way we want to be, and then promote that position.

SUMMARY:

Several approaches to flexible retirement plans of the older worker must be addressed. Legitimate legislation is required to eliminate the restriction of income earned after retirement. Labor and the unions are advocating part-time employment for the older adult by using a flexible retirement model. The expansion of Title IX to hire older adults shows validity of the older workers.

Public relations should (1) show the economic feasibility to retain the older worker, (2) show the types of unique services the older adult can contribute, and (3) show that older adults can easily be assigned team leader roles.

Re-training the older adult will provide the individual with new or improved skills. Sabbatical or mid-career training should be supported by the government. There should be ways to suggest to industry to try out these models. Other careers and volunteer work should be explored.

We must take a philosophical and not an idealistic view and shift to survive. We must state what the values should be.

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THE PUBLIC POLICY PUZZLE: WHERE ARE THE PIECES?

THE FEDERAL POLICY TRAIL

Coordinator: Roy S. Azarnoff, Director, Mayor's Office on Aging, Los Angeles, CA.

Resource Persons: Richard Fisher, Director, Council on Aging of Santa Clara County, Inc., San Jose, CA; Byron Gold, Director, Office of Research, Demonstrations & Manpower Resources, Admin. on Aging, Washington, D.C.; Norine Moover, Chief, Bureau on Aging, Phoenix, AZ.

Recorder: Andree Carlson-Armstrong, Student, Univ. of Northern Colorado, Greeley.

Byron Gold: A historical analysis of the continous process of legislation and regulations and its relationship to the federal policy trail.

There are four policy issues that relate to the federal policy trail:

1) To what extent should programs supported under Title III be focused on low income and minority elderly persons?
2) Can regional offices of state agencies be designated as area agencies in aging?
3) Should a time limit be placed on individual grants made by area agencies on aging to the service providers?
4) Since state and area agencies of aging do not have line control over other agencies, and they have very limited funds with which to purchase their cooperation, how can the annual plans of state and area agencies be given more impact?

What do these four issues have in common?

1) The issues were confronted by AoA during the summer of 1973, as the AoA developed proposed regulations for the Title III program.
2) These issues were answered first in the proposed regulations and then in the final regulations during the late summer and early fall of 1973.
3) While these are all the answers that AoA came up with, they are to some extent based in the law as are all regulations. The connection to the law is at times tenuous.

The general point is that people believe that the policy trail of true legislation, i.e., the legislative process, executive approval or veto, etc., constitutes the federal policy trail. This is not the case. Herman Somers, Professor at the Wade Wilson School, Princeton University, observes what he describes as the "continous process" of legislation. He argues in point in his book (co-authored by his wife, Anne), *Medicare and the Hospitals: Issues and Prospects*, that:

1) The legislative branch phase ends when the president allows a bill to become law.
2) The executive branch promulgates regulations. This function is very much unstudied. There are, from my own point of view, two references known.
    a) One source is the book entitled, *Community Mental Health Legislation: The Formative Process*, by Henry Foley, in which he discusses the issues of regulations promulgated by NIMH and the subsequent implementation of programs.
    b) Another source is a book entitled, *Uncontrollable Spending for Social Service Grants*, by Martha Dertheck, in which she talks about regulatory processes that SRS went through in implementing the 1967 Public Welfare Ammendment which resulted finally in the open end of the Social Security Act for social services being closed and the passage of general revenue sharing occuring in 1972.

There are two processes de facto which form regulations:

1) There is the detailed kind of *public process* like AoA goes through in promulgating regulations and is best illustrated in the Federal Administration Procedures Act.
2) The private process or the closed door process is best described through the procedures that AoA goes about designing regulations, e.g., Title III.

What is it that Federal Agencies do when they promulgate regulations? They do three things:

1) They describe in hopefully articulate terms the program that has been authorized by the law that has been enacted. An illustration of an inarticulate law is Title III. It is an opaque law. The architecture of laws occurs in a particular way because of the necessities of legislative construction. Title III has no logic. It is ambiguous.
2) Regulations should specify what the program is all about and operationalize procedures. One of the functions of regulations is to answer ambiguities in laws. Laws are full of ambiguities as they come through the legislative process. Who resolves these ambiguities? Regulations are placed in which executive agencies can resolve these ambiguities. Regulations are as important as the law itself. They do have the force of the law within the federal courts.
3) Regulations set out programmatic goals. Laws are full of the rhetorical issuances of goals. But implementors at the state level need to know or have a set of expectations that the law charters so that they can measure their own performance. Regulations are a place for executive agencies to set such expectations out.

Why doesn't Congress regulate these sets of expectations out in enacting laws? The four ways to answer this question:

1) Congress doesn't want to get too specific in order to

obtain the legislation. The more broadly a law is drawn, the more likely other legislators will support it. Everybody can then read what they want to in it. The more blank the slate, the easier it is to read one's own interpretations into it.

2) Congress wants to avoid controversy. Generally, the areas that are left ambiguous are recently controversial kinds of matters. Legislators abhor controversy. If somebody has to take the heat regarding the resolution of controversy, better to be a non-elected official than a legislator who must face the voters.
3) Laws frequently involve untechnical kinds of problems that the answers to which require a great deal of expertise. Rather than trying to build that kind of expertise into the laws, themselves, the trick is to design the laws in such a manner that the executive agency presumably has the expertise and can apply the expertise to insure the "legislative points" satisfactorily.
4) The legislative branch frequently maximizes the flexibility of the executive branch. The cooperative kind of relationship between themselves and the executive officials results in a certain latitude in interpreting the statutes.

In recent years that are associated with Watergate, Congress has been more and more reluctant to leave ambiguities in legislation and is requiring an increase in the amount of feedback to Congress regarding regulations and the way the executive branch is interpreting those ambiguities. *This is a new feature of the federal policy trail.* This new issue raises the question, how is it that the executive branch proposes to implement the law? The importance of this question is that the new demand on the part of the legislative branch is that it begins to skirt perilously close to an important constitutional issue. The constitution says that Congress shall make the laws and the executive branch shall carry them out. And, over the two-hundred years of the Republic, both branches have worked out an arrangement by which they stay away from the line, because they do not want to get too close to it. The last couple of years have been featured by both branches overlapping the line, resulting in the removal of the Chief Executive. As a consequence of that unhappy occurrence, Congress has been reluctant to get into the question of, how is the executive branch going to carry out the laws and yet wanting to see the regulations before they become official and final? One indication of that is that it provides both an opportunity and a problem for subnational officials. The opportunity it provides them is if they feel the executive branch is way out of line, it gives them recourse before the regulations become official. The problem is that in a process that is attenuated and time consuming and complicated and frustrating for them it may yet add another layer of frustration. On one hand the executive branch is saying that we would really like to promulgate this legislation, and we would like to clarify the problem for you, but on the other hand, we cannot because we have to take it back to Congress and get their involvement in the process.

Norine Miover: The federal policy trail becomes a crowded freeway with no one sure of which direction to take.

We are reviewing the trail, and if you take the definition of trail to be the means by which you reach a destination, I think we can get to the state level of policy and quickly get lost. I suspect that when you get down to the area agencies, we are more than lost; we are bewildered. The state agency receives the federal policy mandates and are supposed to exercise its options and provide leadership to the area agencies regarding the interpretation of those mandates. My problem is that I can't believe we have all selected the same destination. When we have public hearings in the community, they tell us what they need and how they would like the funds, under the Older American's Act to be used. The area agencies develop an area plan that says this is what the community wants, and the state agency develops a plan that is hopefully representative of the state as a whole via federal mandates. It is here that we run smack into a conflict in the nature of grass roots planning. It is a question of a flow or direction of priorities. Which direction is the state to receive its planning impetus? I have a difficult time trying to understand how we lose that feedback loop which is continuous and should lead from the community to the federal level. It leaves the state unit in an extremely difficult position, because it creates a dilemma between the unit unable to provide the necessary leadership to the area agencies and yet accountable to the federal government for the limitations of their policies and mandates in relation to community priorities.

Richard Fisher: The effects of the current federal policy trail on area agencies on aging.

There are six hundred area agencies on aging in the nation today, and they are a national experiment. Our role as AAAs is to mobilize resources and to push through comprehensive and coordinated social services for older people. We are expected to wear many hats: a planner's hat, an administrator's hat, a coordinator's hat, an advocate's hat, etc., because by the year 2000 A.D., fifty percent of our population will be fifty years or older.

There are forces at work at AAAs and problems that have been created by federal policies and mandates in implementing comprehensive programs:

1) There has been too much emphasis since the 1961 White House Conference on Aging and not enough on action.
2) Service providers have a love-hate relationship with the AAAs due to the symbiotic relationship between themselves and the AAAs in the areas of funding, coordination, monitoring, evaluation, and assessment of programs.
3) Elected officials see AAAs as another resource to tap for votes and monies.
4) Federal policies and mandates continually conflict with the AAAs own local needs and priorities.
5) There is a lack of encouragement for the development of private models for AAAs in contrast to the traditional public organizational model.
6) There is a lack of incentive for reaching the minorities and low income elderly.
7) There is a lack of exchange of information among AAAs that would reduce the overlapping of learning experiences and point out gaps in other areas.
8) There is a lack of technical assistance from the state and federal administrators. The AAAs need program models, monitoring assistance, consumer planning, leadership, in-service training, etc.
9) There is a diffusion of funding sources that reduces AAAs' effectiveness and importance in the aging network.
10) Self-serving advocacy groups and individuals attempt to drain what little power the AAAs have.

11) The AAAs' image with the general public is not good.
12) Inability to carry out local planning mechanisms due to the conflict in the role we play is a part of the dilemma that the state and federal units face, also.
13) There is too much paper work, e.g., proposals, monitoring contracts, writing reports, etc.
14) There is a lack of integration of various titles, e.g., Title VII contracted with the county government, Title V via the state, etc.
15) Congressmen expect input that we haven't got the time to collect; and they expect favoritism.
16) Advisory councils and volunteers come with vested interests attempting to tap instead of giving resources. They also come into the system needing training.
17) News releases of programs emanating from federal policies and mandates leak out before AAAs are aware of them. The press seldom emphasize the positive aspects of AAAs.
18) There is a high turnover of trained, idealistic AAA directors.

There are some solutions that we could try. We need more flexibility, e.g., relax some of the federal requirements. We need longer range area plans; one year is not enough. We need federal and state support in the form of financial, social, and administrative resources. We need some authority and psychological support in coordinating the titles of the Older American's Act.

MAKING TITLE XX WORK FOR AGING

Coordinator: Phillip Hamilton, Director, Title XX Programs, Pima County, Tucson, AZ.

Resource Persons: Richard Bringewatt, Senior Assoc., Assistance-Group, Silver Spring, MD; Fred Lund, Director, Social Services, Region VIII, SRS/HEW, Denver, CO; Harold Salmon, Ph.D., Mayor's OFfice for Senior Citizens, St. Louis, MO.

Recorder: Joyce Olson, Aging Services Coordinator, Minot, ND.

Title XX of the Social Security Act puts the states in the drivers' seat in describing services to be administered at the state level; in the implementation of this Act there are over 1300 different service definitions used by the states. This local decision-making capability benefits the State Agency on Aging. The local legislature controls Title XX in each state. Thus political clout governs these decisions, and to utilize Title XX fully for aging services, aging program people have to mobilize politically. However, each Title XX State Plan must address five mandated goals, with one service for each goal, and 50% of these funds are used for SSI and AFDC. These restrictions limit spending options available to aging programs.

In this workshop Title XX was addressed in conjunction with Title III and VII of the Older Americans Act. Eligibility determination was seen as the primary problem in integration of these three funding streams. The process of determination differs from state to state, and the administrating organization has the responsibility to delegate determination of eligibility. An eligibility card can be used if the state allows this. Group eligibility is allowed in poverty areas, but *this has to be part of the State Plan.*

To use this record-keeping shortcut, define your group; if it has no less than 70-90% eligible, it is eligible. For group eligibility to be included in a State Plan, the state must subsample the population with the assistance of the Feds. Gross income must be no more than 90% of the median income. Inclusion is dependent on the geographical area and the nature of the community, based on the state's median income. (This is in the Federal Register for each state.) The Federal guidelines for group eligibility include everything but Day Care.

In computing match monies for Title XX there is a possibility that client-generated fees can be used for match if they are treated as earned income rather than donated income. There is federal uncertainty about this, however.

At this workshop Title XX was presented from two perspectives. First, the State organization of the Title was discussed, with Pennsylvania's system as an example, and then potential City usage, with St. Louis as the primary city discussed.

Pennsylvania:

In Pennsylvania, Aging Services are as much a public responsibility as the Department of Youth Services. It is assumed that all elderly should be served on the basis of need, with equality of services for both rural and urban residents. Services are designed to cover the full spectrum needed to maintain independence.

Administration is decentralized as much as possible with overall planning of the total package. These services are coordinated and organized from the perspective of the client, not of the program. Responsibility and authority go hand in hand, with overall responsibility of local programs resting with a single agency so the client can hold a single source accountable. It is felt that the administrative system should be simple and support efficient delivery of services.

The Pennsylvania system was developed with 47 county-based area agencies. Title III, VII, and XX are allocated through these AAA's, with 30% of the funding being title XX. The State Agency is part of the State Social Services Board. All funds are contracted through the AAA's, with a single plan per calendar year relating to each unique funding stream.

A full continuum of services is provided, mostly through contract. There is no means test, but voluntary information gathering is used. Each client is aware that no Title XX reimbursement is made without documentation, and voluntarily complies. All service reporting is part of a unified system covering all three Title sources.

There are problems involved with funding integration. SSB administration causes difficulty, as the elderly are reluctant to take welfare. AoA and Title XX regulations were not totally compatible, nor were procedures. Regulations for Title XX reimbursement required a means test where Titles VII and III do not, for example. The allocation and planning process was difficult in developing a coordinated system. State regulations for Titles III, VII and XX were not totally compatible and had to be meshed.

Two basic issues were the means test under Title XX, and the integration of planning and management procedures. Voluntary income information collection was used to meet the first, and integration of planning and management procedures were essential in meeting the second. This involved the development of a standardized set of service definitions broad enough to meet all requirements and specific enough to fit both sets of Federal requirements. What was developed, then, was a compatible set of cost allocation procedures and cost allocation categories. It is recommended that you start from an Aging base, as Titles XX, III and VII are compatible but neither has a way to provide all services needed. This requires tenacious diplomacy and the ability to utilize a broad range of options.

St. Louis:

At the city level, it was felt that Title XX is so intricate it is difficult to administer, but nonetheless St. Louis is utilizing $2,000,000 of Title XX funds successfully.St. Louis has the largest Title XX program in the State of Missouri because the director is persistent in trying for Title XX funding. Another reason for this success is that total city support of aging services generates statewide support. The City as a whole will not take "NO" for an answer; the State of Missouri turns back ⅓ of the money allocated and the City of St. Louis refuses to allow this.

The recipe for Title XX usage in a city setting can be broken into two broad categories:

(1) General Preparation: Learn the salient features of Title XX; study and master the regs, attend hearings, search for shortcuts. The NCOA has helpful publications on the basic components of Title XX for aging programs (1975) and on the integration of Title XX with other services (1976). Learn the important features of Title XX in your State; become familiar with the State Plan by checking back years to see if aging programs are being supported and how this is being done. Take a look at the present state of affairs, the amount turned back for lack of match, the actual amount being spent for aging programs.Check how this money is being used, whether to retain present programs or to develop new ones, and on how long funds have been used for specific programs. Use precedent: "Where the tracks are laid the train will run." If necessary, set precedent. Get involved with the Title XX process in every way possible. Learn the schedule of hearings in your state and feed into preliminary hearings. Learn the role of your State Office on Aging in the Title XX process. Is it involved or aloof? Exert pressure to get it involved. A program regulation guide published by HEW is available as an interpretive guide; study it to get insights into possibilities and use it to deal with the agency head in charge of Title XX.

(2) Specifics to do immediately: Develop concrete plans regarding the match your community will contribute. Be certain about the dollar amount available and on what date it will be provided. Sell your program at the State hearings, write letters to the State Title XX agency, document requests for your participation in Title XX.

Title XX administration is regional; become familiar with your federal field representative. Also, use political pressure to implement your proposals. A mayor's representative or city manager may provide this pressure for you. Be persistent to the point of being a nuisance once you thoroughly understand Title XX and have a concrete proposal. Get State Agencies to expand their staff to help you take advantate of Title XX. Tailor your personality to be successful. This requires toleration of ambiguity, patience, and persistance. Use the State Office on Aging to facilitate and implement integration of Titles III,VII, and XX at State level so that the City will have use of a coordinated funding source. There are two models of service delivery, integrated or separated.It is best to start with the integrated model so that there is no title differentiation of clients.

In conclusion, the statement was made that Title XX is not there by the grace of some administrator, it is there to be utilized. Aging service delivery agencies have a responsibility to the elderly to use it fully.

FEDERAL PUBLIC POLICY PRIORITIES

Facilitators: Elias Cohen, M.P.A., J.D., Proj. Dir., Aging & Long Term Care, PILCOP, Philadelphia, PA; Paul Kerschner, Ph.D., Dir., Community Programs, Andrus Gerontology Ctr., USC, Los Angeles, CA.

Recorder: Marcy Stanley, Student, San Jose State University, CA.

There was no structured format in this roundtable discussion. The following report will cite the important or outstanding topics in their order of discussion. We initially talked about how priorities are established and finished with what may be considered top priorities for older persons.

Methods of feeding information from local level to federal level:

Surveys

Needs assessments

Both of above leading to state plans and justification for allocation of funds.

Very expensive to obtain valid needs assessment - and very often fictionalized. Surveys are expensive.

How do we evaluate needs and how do we mediate between needs and preferences?

For example, we as seniors may need better food, but we may *prefer* recreation.

We have gotten locked into housing, nutrition, etc., as needs, but we have to deal with preferences; also do we deal with the preferences of the poor elderly or with the preferences of the affluent elderly?

We are not teaching the planners and agencies how to evaluate elderly needs. (This was illustrated by a senior citizen in the discussion group who told about conditions in her community. It seems that the Citizen's Involvement Committee in her area asked and obtained senior citizens' needs there. When the Committee presented these needs to the City Commissioners, nothing at all was done about them; rather, the Commissioners continued to please the powerful and influential interests in the city.)

Political influence is needed for the elderly. It is difficult to obtain. Politicians seem to vote for the articulate constituency.

Pockets of Power:

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Lobbyists - that's where the money is. Lobbyists articulate and infiltrate at all levels of government, and the decision making process starts right there, where all these different levels and departments become informed and propagandized.

How many letters can seniors deliver? Will seniors write letters urging increase of SSI state subsidies for example?
Data based or "feeling level" based information to establish priorities? Which is to be used?
HIGHEST PRIORITIES
Ethical imperatives:

Better homes - better care - better transportation (rather than consideration of how much money we are spending).

Good programs and services for elderly who can no longer help themselves. We must consider needs as well as preferences.

Need to coalesce to change economic system; effect tax reform, improve imports and exports, (one-third of workers in shoe industry in Pennsylvania since 1965 are out of work and those over forty-five almost unable to return to labor market because of their age). Need guaranteed annual income that will ensure the expensive dollars paid into social security system by seniors will be equalled by cheaper dollars returned to them when increased inflation continues.
Multi-billion dollar programs needed to reach hard-to-reach elderly. Our present priorities mostly save the already saved. We must reach the most isolated.
Diversity in regulation writing to take into account the differences among different communities. We cannot generalize, and we must consider each state and local community individually.

VOLUNTARISM AND THE ELDERLY

VOLUNTARISM AND THE ELDERLY: EXPLOITATION OR ENRICHMENT?

Coordinators: Helena Hult, C.V.C., Dir., Senior Service Center of the Santa Monica YWCA, CA & Mary Seguin, D.S.W., Field Coord., Leonard Davis School of Gerontology, USC, Los Angeles, CA.

Resource Persons: Cora Cocks, Chairperson, California Commission on Aging and Fulltime Volunteer, Planned Parenthood, Counseling, Long Beach, CA; David L. Crippens, Vice-President for Educational Services, KCET (Channel 28), Los Angeles, CA; Andrew Gutierrez, Mayor's Office on Aging, Los Angeles, CA; Mary Ripley, Co-Founder and immediate past President, International Assn. for Volunteer Education and Natl. Conference of Social Work, Los Angeles, CA; Mary Vwegrzyn, Member, NOW, Denver, CO.

Recorder: Ms. Ione Grannis, Candidate for Certificate in Gerontology, Leonard Davis School of Gerontology, USC, Los Angeles, CA.

Dr. Mary Seguin gave reason for the workshop: Most of us have felt both enrichment and exploitation as volunteers. The issues are real for both experiences. The panel wants to get behind generalities so we can go back home with a sharper perspective of the subject. If we are to get the work of the country done, we must get involved and must exhibit flexibility in meeting needs.
David Crippins stated that: We must recognize what volunteers do that is different; we must reimburse for out-of-pocket expenditures; we must deal with the threat volunteers are to paid staff, especially paraprofessionals. If older volunteers are attracted, the environment should be conducive to growth and should result in enrichment and personal growth.

Panel Presentations:
Andrew Gutierrez dealt with *exploitation* in relation to religious and charitable organizations. He believes exploitation is done in the name of brotherly love and similar motivations. Although he recognizes legitimate functions for volunteers, he sees two areas of exploitation, i.e., educational programs and money raising schemes. Except for one or two professionals, most of the educational work is done by volunteers with little or no training. He questions whether untrained people should be trusted with such critical aspects of life. He saw this as exploitation of those serving and those being served, many of whom are elderly.
He used as an illustration of money raising schemes, a church with 84 family units of professional and business people, having an aggregate income of $1,370,000. Their current budget is $54,000. Instead of the members contributing according to their income, the church uses dehumanizing processes of raising money, which rob people of their dignity. He sees the elderly as victims of this process as well.
Cora Cocks sees voluntarism as *enrichment*. She speaks from the vantage point of 48 years of experience. She has run Christmas Seals sales, done PTA work and now runs a birth control clinic through which she has had contact with 8,000 females. She is known among the young as the "Sex Lady" and says she takes care of people sexually involved from "erection to resurrection." When the young people told her she was elderly, she became interested in "Sex After Sixty." Having recently become a widow, she wants to keep busy, so for her voluntarism is enrichment. She does not feel exploited - in fact she believes one is not exploited unless she allows herself to be. To her, successful volunteering depends on what happens inside the volunteer. She would not change her life.
Mary V. Wegrzyn presented her concern about *exploitation*. She recognized that historically America has excelled all

other nations in the utilization of volunteers. Having worked as paid as well as unpaid, she saw the *exploitative potential.* The four areas of importance were listed as: 1. Church and such agencies as mental health, Red Cross, etc.; 2. Political action - carrying signs (such as Gray Panthers at the conference); 3. Crisis oriented - like giving blood, short term efforts which are part of the fabric of society; 4. Continuing services - the schools' use of untrained people, where the work of one paid, trained worker is supplemented by many without training. She labeled this the school's cheap way of meeting its obligation.

An example was given of the development of a sense of worth in the volunteer. The Red Cross trains its Nurse's Aides impeccably. The team approach is used and recognition given to the volunteer by professionals. Although this has value for the volunteer, it delays institutions in providing budgets for adequate staffing for good service delivery. This was considered an indirect exploitation of the elderly, in undelivered services.

In the use of senior volunteers, she recommended short hours and flexibility, with back up substitutes so the senior could leave when necessary without the feeling of letting the staff down. She suggested the provision of transportation, hair care and out-of-pocket expenditures for volunteers unable to afford them. Recognizing that voluntarism had been largely an upper, middle class characteristic, she placed a $20,000 value on her volunteer experience of twenty years. If she had banked the money, she could have given her five children a college education.

Danny Kleinman - an honor student from Crossroads School in Santa Monica spoke enthusiastically of his experience as a volunteer giving service to older people. At age thirteen he became aware of the plight of migratory workers. This was further enhanced when he helped Tom Hayden in his work with the United Farm Workers. He recalled helping an older woman get better medical care through his contact with the Senior Service Center in Santa Monica. Such agencies cannot afford to pay for the type of service he can provide. He believes he has been helpful to others in bringing about changes for the better. He sees this as personally *enriching* for him.

After the panel presentation, the workshop broke up into groups of six to eight with a facilitator at each table. Discussion was enthusiastic and conclusions were reported back by a recorder from each table at the end of the session.

Statements related to *exploitation:*

Some remuneration should be considered for minorities and volunteers on fixed incomes.

A volunteer should be given the option of being paid or not.

Stipended jobs should pay minimum wage.

When required to travel long distances, mileage should be given.

Voluntarism is a numbers game for budget purposes.

Volunteers should not be used to replace paid staff.

A monetary value should be placed on the jobs done by volunteers.

Agencies should be honest about exploitation - lay it on the line.

Whereas paid workers have limits on time and tasks performed, volunteers may not know what is expected of them.

Volunteer jobs should not be 'busy work' for seniors.

Some jobs give little or nothing to the volunteer.

Volunteers may not have sufficient counselling to feel adequate.

Attitudes toward volunteers should not be denigrating nor resentful.

Volunteers can also exploit agencies as volunteering may be used as a step toward employment.

Enrichment is enhanced by:

Mutuality of benefits and personal growth.

Recognition of the need so both agency and volunteer appreciate the job to be done.

The degree of importance of the agency to the volunteer.

Careful linkage between the talents of the volunteer and the job to be done.

The development of a sense of worth.

The establishment of agency expectations.

Placement in a job that is interesting and meaningful.

Finding an area of usefulness to society to replace a sense of uselessness.

An opportunity to learn new skills - a free education resulting in growth.

Reimbursement making possible securing the best available volunteer.

A film entitled "Thelma and Cindy" was shown based on a one-to-one contact between a young person and a senior, both of whom were female. It accented the mutual benefits accruing from a cross generational relationship and both participants expressed their hope that others might have a similarly satisfying experience.

SUMMATION: *Dr. Mary Seguin*

Recognizing that we are part of fifty five million volunteers, the workshop was thought to be a way to bring to the public a discussion of how voluntarism can become enriching. It is important to get communication going so our potential can be enlarged and made available to us no matter what age we are.

NARRATIVE: *by Jeff Ross, M.S.G. candidate, Leonard Davis School of Gerontology, USC, Los Angeles, CA.*

Since mandatory retirement is a means for getting people out of the labor force, paid employment is not likely to be a viable career option open to many older adults, even with retraining. Consequently, positions in the voluntary sector may offer a greater potential for maintaining careers that afford older individuals social identity as well as opportunity for contributing to the common good. Moreover, voluntary positions may afford flexibility in commitment of time, energy, and the pooling of manpower resources that permit older adults freedom to explore new life-styles not possible under the constraints of time spent in paid employment.

Still, what of these volunteers who are in need of funds to survive comfortably? Are they being exploited in their search for personal growth? Let's take a look at some of the salient issues defining the problem of voluntarism: enrichment or exploitation?

There are those who contend that volunteers gain personal growth or enrichment from their work. To these people the essence of volunteering is being free to do what one wants to and receive some kind of satisfaction that one does not get in other activities. Knowing that the service means more because it is given freely is not a small reward. People, regardless of economic condition, have a right to engage in meaningful work, to contribute to society. Unfortunately, the elderly, like other minority groups, have been exploited economically within our society. How can we expect them to do unpaid work?

Reimbursing volunteers for out-of-pocket expenses seems now to be generally accepted, but the lines of demarcation between volunteer and paid personnel are not clearly drawn. This presents another problem; in some situations volunteers have been seen by paid staff as a threat to their positions, especially by paraprofessionals who may be in the process of establishing themselves in their positions. Which jobs within an organization should be filled by volunteers and which by paid workers? This is often not established. What can volunteers do that is different from that of other workers? Is there any task that is clearly for a paid worker?

If the older person is to be attracted and held as a volunteer, ways must be found to meet the complex set of conditions that satisfies him, and to alter the circumstances that dissatisfy him or prevents him from volunteering. Whether an individual is enriched depends on what personal growth he encounters in the volunteering process. It is the duty of the organization to establish a working condition that is conducive to this growth without exploiting the volunteers efforts.

RIGHTS/RESPONSIBILITIES/STANDARDS: FOR ORGANIZATIONS AND FOR VOLUNTEERS

Coordinator: Beverly A. Calton, Program Director, RSVP of North Orange County, Fullerton, CA.

Resource Persons: Ruth Conrow, Dir., Foster Grandparent Program, Salt Lake City, UT; Dianna Kunz, Proj. Dir., Seniors Nutrition Program, Denver, CO; Lois LaCroix, Dir., RSVP of Denver, CO; Henry Marx, Senior Volunteer and Chairman, Denver RSVP Advisory Council, CO; Martha Mull, Dir., Office of Volunteers, Mile High Chapter of American Red Cross, Denver, CO; Harold Zier, Instructional Consultant, Denver Public School System, CO.

Recorder: Joe Ann Hyer, RSVP Director, Norhtern Marian County, OR.

Beverly Calton introduced the panel members. She stated that we would not get into recruitment or motivation for volunteers to come into community service. The first part of the program included personal experiences related by each member of the panel.

Harold Zier stated that his goal was to bring people from the community into the schools to see how they function and be aware of what the schools have. The various needs for volunteers were:

1. Volunteers tutoring youngsters, individually or in groups.
2. Supervising youngsters.
3. Resource specialist - to share talent, show slides, talk about travels.
4. Teacher assistants.
5. Help in the office with using copy machines, typing, etc.

Denver has 121 school buildings, and only 97 are actively using volunteers. There are 1,190 registered volunteers in Denver and they donated 1,012 hours of voluntarism last month. They put in 7,234 hours of service to youngsters and teachers in the schools during the year.

The goal of recruitment was accomplished by holding regional cluster meetings, and inviting PTA members, parents and the general public. At this meeting, an orientation on the program was conducted. This program is now 8 years old. The volunteers are non-salaried employees of the school district and they are covered for liability insurance. The school pays the premiums.

Martha Mull was the second speaker and she reported that there are over 8,000 volunteers with the American Red Cross, which is one of the oldest volunteer organizations in the world. The skills the volunteers bring are new or formerly overlooked. Senior citizens educate and develop young volunteers. They act as interviewers, trainers, hospital volunteers (including veteran's hospitals), school health volunteers, friendly visiting, telephone callers, nursing home aides, drivers, crafts, sewers, clerical aides, disaster team members, services to Armed Forces, host-hostesses, instructors, public information, bookkeeping accounting, administrative aides, (board members, program chairpersons).

She explained the various duties of each of those jobs listed and the sort of training that is required for some of them. She said it is important to always remember that volunteers MUST have a satisfying, rewarding job. They must be happy and successful.

Dianne Kunz told about the meal sites in Denver. Denver has 30 meal sites and they serve 1,300 meals each day. Last year 3,500 volunteers donated 35,000 hours of their time. By law, there must be 8 support services provided. The volunteers provide transportation and information and referral service. They have retired health services such as blood pressures, podiatry, glaucoma tests. The escort services to the meal site is provided by a personal friend or van or car. They must make them comfortable, introduce them, provide support for a week or two until they are acquainted.

The meal site maintains a list of seniors with talent and the site coordinators utilize this for entertainment. Support services and utilization is as important as meals. Volunteers act as host and hostesses, greeting people, introducing them to others. The most important people are the volunteers. Administrators can be absent for long periods of time. The volunteers keep the program going.

Henry Marx, a senior citizen, explained his philosophy that professionalism is no prerequisite for volunteer work but financial security is. He stated that background is important in voluntarism. He talked about the RSVP advisory council bylaws. He shows slides of the schools on his travels. He said that the reason he volunteers is that a life of leisure only too soon becomes boring. He said, "I volunteer in my own interest." The most impossible task of agencies is to tear seniors out of their confines. Past experience sometimes narrow attitudes instead of widening attitudes. He reviewed the "Code for Volunteers" and called attention to the last paragraph that discusses contributions to human betterment.

Ruth Conrow stated that volunteers are very important. Volunteers have a right to have their job be a meaningful experience; fulfilling and rewarding. The time must be well spent. She described the contents of the packet that was distributed. Included in that packet is a "Bill of Rights for a Volunteer." She read the Bill of Rights and defined the meaning of each point included in it. She stated that the author is unknown. It is actually a culmination of a great many people; it is not copyrighted so it can be copied for other organizational use. The packet was developed as a manual for school volunteers. The packets can be used for guidelines for local use if desired. Included in the packet is "Standards for Organizations Utilizing Volunteers," a complete job description. Sometimes, organizations dealing with volunteers have a problem deciding how to handle volunteers that are not capable of handling their jobs. Many problems like that can be corrected with complete, thorough orienting of volunteers. An advantage of a senior volunteer is the options open. If a station is unhappy with a volunteer or a volunteer is unhappy with a station, it can be resolved. It is extremely important to be candid. On the monthly report from the volunteers an addition could be made at the bottom stating, "Are you satisfied with your volunteer work?" This gives the volunteer an opportunity to reveal a problem if one exists. It is a good idea to have job descriptions for the volunteers and conduct interviews for the various jobs. The agencies can write the job description. Transportation should be available for those needing it. It is extremely important that the volunteer know what is expected, the exact duties and what resources are available.

RECRUIT, TRAIN, RETAIN AND REWARD

Coordinator: Don L. Brown, M.A., Reg. Dir., ACTION, Region IX, San Francisco, CA.

Resource Persons: Denise Pickering, Proj. Dir., RSVP, Culver City, CA; Patrick J. Twohig, Prog. Operations Officer, ACTION, Region IX, San Francisco, CA; Sam Velez, M.A., Training Officer, ACTION, Region IX, San Francisco, CA.

Recorder: Bill Montgomery, Graduate Student, Leonard Davis School of Gerontology, Univ. of Southern California, Los Angeles, CA.

RECRUIT

A formal recruiting methodology that "doesn't rely on luck," includes the following steps: 1) through proper management, plan your recruiting far enough ahead to be able to really state what types of people are needed, and to allow for finding them; 2) define the target population to be canvassed for volunteers; 3) locally advertise, describing the tasks involved, visit the personnel departments of local companies and use the local media by offering them "human interest stories"; 4) code responses to the campaign according to the method that brought each of them in. Person-to-person recruiting was seen by several in the audience to be superior to this model, but was judged by some on the panel to be only "relatively so." Other alternative models of recruiting discussed were putting inserts in utility company billing statements, and enlisting the assistance and endorsement of leading local social institutions.

It was suggested that recruiters should be careful in selecting copy for advertisements. Certain words alienate people from a program. One such word is "volunteer." To some people it may suggest that a paid worker is being robbed of his job, or that an employer is exploiting a person who isn't in a position to demand remuneration for his/her work because of age, or other conditions. Additionally, many World War 1 veterans remember being told to "never volunteer for anything." The term may lack the prestige that words such as assistant, or project aide have, as well.

TRAIN

There are three types of training that ACTION management is concerned with: 1) Pre-Service Orientation familiarizes new people with what is expected of the program, and of the volunteers; 2) In-Service Training deals with problems encountered in the field, and supervisory techniques such as volunteer management and use of advisory boards; 3) End-of-Service training is concerned with helping people get back into the job market after their stint as volunteers. There were no comments or additions to this, except for the suggestion that volunteer supervisors could hire temporary trainers as consultants for programs discussed above.

RETAIN

Keeping individuals involved in volunteer work once they have been recruited depends in large part on how well they have been placed and on the way they view voluntarism itself. It was suggested that a major part of the initial interview with a prospective volunteer be spent finding out not only what he/she wants to do, but also what he/she does not want to do. If a person does not appear to be satisfied with one position, move him/her to another. Be careful to avoid underestimating the abilities of volunteers, especially of males.

The image of volunteer work that is presented is also important. Do not ever refer to these workers as "only volunteers." Avoid suggesting that volunteer work is free work, and instead refer to it in terms of being a good neighbor. More flattering terms to describe workers may also be used, such as staff aide, or assistant. Even though retention of volunteers is an important issue, we should also keep in mind the greater issue of personal independence. No volunteers should be encouraged to become so involved in voluntarism that their entire lives revolve around their work in it.

REWARD

It is important to reflect on just what personal meaning voluntarism has in the lives of individuals one works with. It is possible that being a volunteer is actually reward enough for a person. Likewise, if rewards for service are to be given, their meaning should match the volunteer's style and level of involvement.

There are both formal and informal types of rewards. The former type includes such things as certificates, plaques, gifts, dinners, formal training, being asked to help make decisions, or to represent the staff at a meeting. The latter type of rewards include such personal actions as smiles, handshakes, greeting a volunteer by name, etc. It is necessary to continually anticipate the changing values of the volunteer staff so that the rewards that are chosen will be meaningful. Beware of planning rewards of public recognition, since some persons would prefer not to be mentioned in the media, or have their pictures taken. It was suggested that workshop participants review a list of "101 Ways to Give Recognition to Volunteers," by Vern Lake, Volunteer Services Consultant for the Minnesota Department of Public Welfare.

Finally, it is important for the volunteer supervisor to keep his perspective on the awarding of rewards. For instance, rewards and ceremonies will frequently snowball, becoming larger or more involved each year until they are impossible to manage. If not kept under control, such increasingly gaudy affairs may threaten either the program's solvency, or the proper value orientations of all involved.

The key to properly managing voluntarism and to making it a success is to be able to control the project's destiny, and its effect on the lives of those involved. The tremendous growth of voluntarism and the changing popular conception of what it involves, makes this a very challenging field to be in.

THE MINORITY PERSPECTIVE OF VOLUNTARISM

Coordinator: Jess Sixkiller, Arizona State Director, ACTION, Phoenix.

Resource Persons: Sadie Curry, Director, Senior Companion Program, Phoenix, AZ; Percy Deal, Director, Foster Grandparent Program, Navajo Nation; Nydia Martinez, Director, Retired Senior Volunteer Program, Phoenix, AZ.

Recorder: Kenn Netzel, Director, Retired Senior Volunteer Program, Vancouver, WA.

The purpose of this session was threefold: first, to raise the awareness of utilizing minorities in volunteer services; secondly, to share the complexities of recruitment, placement, recognition, and benefits of using these volunteers, and thirdly, to reveal possible solutions to the questions about involvement of minority volunteers.

Summary: Presentations of Resource Persons

When recruiting the minority volunteer, the mass media is generally not very effective. It must be realized that these people are struggling day to day to survive. The impersonal approach through radio and T.V. does not reach their need to be involved in something meaningful. The newspaper is somewhat effective; however, approximately three percent of the minority population are literate or ever see a newspaper. The telephone has limited effectiveness, also, as most minorities cannot afford such a luxury.

A second problem in recruiting deals with the lack of confidence on the part of minorities in federal programs. One must realize that with the abundance of these programs today, many have not been successful. Thus, after the minority person has been sold on a program, it is terminated due to lack of funds, or the individual is rejected because he does not qualify.

To successfully recruit these minority persons, one has to first find a means to reach them and then a method to build their confidence in the program. This may best be done by personal contact and word of mouth. Contact could be made through senior programs which would involve your target group, i.e., senior nutrition programs, senior centers or churches. The next step is to find and sell the peer group leader on your program. You may utilize this person as your recruiter and possibly even hire him. Try using current volunteers in your program, going door-to-door with you to the homes of prospective volunteers. You may also use these volunteers to refer friends or neighbors as volunteers for your program.

Once you have recruited these volunteers, placement and orientation are very important. A crucial problem which must be considered is transportation. If these people own a car, it may not run or it may run very poorly, and they probably cannot afford to buy a new one. In certain regions, road and climate conditions may be other factors you might need to consider. Thus, it is necessary to place these volunteers as close to their homes as possible. A one-mile radius is suggested. An additional consideration is that of language. A volunteer will feel more comfortable if he can understand and communicate with those with whom he is working.

To retain these people as volunteers, try to place them in a job doing something they have always dreamed of doing. And when orientating these new volunteers, be specific as to what duties they are to perform and what is expected of them. Tell them, also, what they can expect from you.

Recognition is also very important to these volunteers. The more successful events, in the past, have allowed the volunteers to do the planning, arranging, and executing of the event. It is important to give awards. These may be certificates, membership cards, plaques, pins or badges. Whatever the award, it is very important that it identify the volunteer as a member of a group. This helps greatly towards self-esteem. If your program has a stipend, this may be the necessary award in the beginning. However, as time passes, the money becomes less important and the desire to be of service and recognized as "somebody" for possibly the first time in their lives becomes more important.

If this desire to be of service stimulates the volunteer, he may become involved in other volunteer programs. The program director will then need to be on the lookout for the "volunteer burn-out syndrome", as a symptom to this syndrome. The volunteer becomes tired of volunteering, according to this syndrome, and his production drops off. One other symptom of this syndrome can be poor health brought on by too much activity. These problems can be alleviated if the director works with the volunteer on the area of amount of involvement.

Summary: Small Group Discussions

1. What approaches should be used in recruiting minority volunteers?

a. Word of mouth is best. There is need for one-to-one contact to build a firm foundation of trust. Begin with presentations at places where the target group congregates, i.e., senior nutrition programs, churches, senior centers, etc.

b. Hire the peer group leader to recruit volunteers: the

NAACP churches with large minority congregations, etc., are good places to start.

2. What needs should be considered in developing work assignments for minority volunteers?

a. Allow the volunteers to participate as peer group. This will help with personal security and comfort zones.

b. Assign the volunteer to something he has always wanted to do.

c. Assign the volunteer where the same language is spoken and, if possible, the same dialect.

d. Educate the volunteer agency staff and volunteer supervisor in the techniques of working with minority volunteers.

3. What additional benefits accrue for the projects, the clientele, and the larger community due to the involvement of minority volunteers?

a. An understanding of the people and problems of the minority is promoted.

b. A common communication link - volunteers can make agency clients feel comfortable because they speak the same language.

4. How should minority volunteers be recognized or rewarded?

a. Get to know what the volunteers define as recognition by understanding what makes them feel good and what is comfortable.

b. Understand who their peer groups are and where the volunteer stands in that peer group.

c. Find out what the volunteer's aspirations are.

d. Recognize the volunteer within his peer group as well as outside: listing volunteer's names in the newspaper would be a good start.

e. Recognize the volunteer at his work site for the role he plays.

As an overview to the total session, there are eight points to be remembered.

1. The program director must learn how communities perceive voluntarism.
2. Understand what constitutes a minority community - what institutions and people do they respond to.
3. Identify the opinion leaders.
4. Determine what types of needs communities will respond to.
5. Set up meetings in the communities to promote the program, being sure a member of the community who endorses the program is present.
6. Set up work assignments which address the needs with which the community identifies.
7. Support the volunteers in their work station. Work to build each volunteer as a person, by changing positions or assignments if problems cannot be worked out.
8. Recognize the volunteer and his efforts within the boundaries of his definition of recognition.

INGREDIENTS FOR DELIVERY OF HUMAN SERVICES

GROUP ACTIVITIES: THE MEANS OR THE END?

Coordinator: Priscilla Ebersole, R.N., M.S., Asst. Prof., Dept. of Nursing, San Francisco State Univ., CA.

Resource Persons: Mary Jane Hennessey, R.N., M.A., Music Consultant and Professional Musician, Carmel, CA; Pat Hess, R.N., M.S., Asst. Prof., Dept. of Nursing, San Francisco State Univ., CA and Author's Consultant, Death and Dying; Helen Elena Monea, R.N., M.S., Consultant, Proj. Outreach, Staff Development, Long Term Care Facilities, San Francisco, CA.

Recorder: Patricia Grinager, Ph.D., School of Nursing, Univ. of Wisconsin, Milwaukee.

Participants who came to this session got three chances to choose from five different group activities going on in or near a large room.

In one corner Mary Jane Hennessey inspired conferees to eeee, ahhh, and ooooh in multi-tonal unison. She produced instruments on which to pick out rudimentary rhythms. She enticed group members to dance to the beat. Smiles predominated as members of a group who "knew nothing about music" ended up singing such oldies as "Down By The Riverside" with gusto.

In another area, Priscilla Abersole suggested ways to get older people reminiscing. Foods and horehound candies trigger memories. So also do questions as to how houses of the past used to be heated; what favorite subjects in school were; whether a father wore a hat or not and if so, what that hat looked like. After such sessions, she explained, oldsters have something tangible with which to start up conversations and go about establishing newfound relationships.

Pat Hess probed feelings about death and dying. "I've noticed I don't plan for the future so much any more," one man said. "There's so little time left," a woman added, "that one has to live one's life in depth."

Rudeen Monte employed a small portable TV camera to record movements of people in her groups. "Imagine you're a block of ice," she told them. "I am the sun and I've come to melt you down." When the conferees had slowly "dripped" to the blankets she had laid out on the floor, she next encouraged them: "Curl up in as small a ball as you possibly can. Imagine that you're the seed of a flower. Decide what kind of a flower you want to be. Now grow into that flower." When all the newly metamorphized posies had reached their prime, she teamed them off in pairs and suggested they take turns mirroring the actions of each other. As pairs grew less self conscious, their movement evolved into spontaneous little dances. All of this made for a fine television show. "Seeing oneself perform on TV gives one a feeling of being much more worthwhile," Rudeen commented while those who heard her nodded in agreement.

In a little alcove off the main room, blonde Helen Monea dressed as a black-haired Japanese and conducted a mini-workshop in sensory awareness. She concentrated on the senses of smell and then of touch while scented candles flickered and a phonograph gave off wounds of softly playing Oriental music.

During the last half hour of the afternoon, pleasured participants shared reactions to and feelings during their separate experiences. Each of the five young women conducting the sessions are nurses who work in group activities with older people. Irene Burnside kept track of the time throughout the sessions. Her latest book NURSING AND THE AGED, describes these and other activities for persons who are looking for creative ideas in their work with groups of older people.

MINORITY GROUPS: A SPECIAL APPROACH?

Coordinators: Duran Bell, Jr., Ph.D., Assoc. Prof., Economics. School of Social Science, Univ. of Calif., Irvine & Ramon Valle, Director RISE, Center on Aging, San Diego State Univ., CA.

Resource Person: Sophie Thompson, Social Worker with Navajo Indians, Window Rock, AZ.

Recorder: Joyce Olson, Aging Services Coordinator, Minot, ND.

This workshop first recognized commonalities among minority groups; these include pervasive poverty, low socio-economic status, and a linguistic and cultural separation from the nation's mainstream. In discussing human service delivery to minority groups from a policy and planning perspective, however, the focus was on inter-ethnic variations in perceived needs, in coping patterns, and in other factors influencing aging program involvement and service delivery to each minority group. Two keys to ethnic involvement in aging programs are bilingual service delivery staffing and strong senior advisory councils made up of members of that ethnic community, to help plan senior meals, organize center activities, and to develop the entire aging program.

Typical of the problems unique to individual groups are those of Japanese returning to America after being in Japan for a period of time, the Native American problem caused by the confusion of 300 treaties and 3000 administrative orders, all broken, and of elderly Latinos who are taken from their families and returned to Mexico because they lack the "green card." A problem common to all is the widening difference of experience as the younger generations culturally move away from their elders.

The Native American representative, Sophie Thompson of Window Rock, Arizona, is a Social Worker with the Navajo. She stated that the term "American Indian" is an unacceptable categorization because of the diversity of tribal culture and of reservation problems, both geographical and political, as well as of the urban Native American diversity. Some surface commonalities such as functioning within jurisdictional land areas, of having the label or definition developed by people other than the Native American attached to the individual, and the treaty relationship to the government do exist, however.

Problems common to many reservations include the extreme distances involved, where going for groceries can be a whole day's job, the poor roads, no public transportation, and having no one to watch the immobilized old people while the younger ones are getting provisions. Language problems include not speaking English, the language of the service providers, and not having enough Native American service providers available. Jurisdictional problems arise because reservations often straddle state lines, and human service development is often in a primitive stage because of this. The Indian Self-Determination Act and the Indian Health Act are aimed at Indian involvement, but lack of trained Native Americans keep these from being effectively self-run.

Congregate meals at reservation community centers are successful because meals are a way of socializing and giving elders a reason for getting out and back into the mainstream. Programs are slowly increasing on the reservation, but on the whole the older people have been overlooked, with 80% of the funds going to the young through pre-natal care, Head Start, Day Care, etc.

With the urban Latino elderly, the language barrier may prevent using services such as dial-a-ride. The family as well as the Catholic Church is a strong support within this group. A factor recognized through a recent San Diego study is that of the broker, a non-paid, community facilitator helping the elderly individual use the available service delivery systems. On Indian reservations, the Community Health Representative may serve a similar function.

Activities suggested for Mexican-Americans include making poems and plays about the "old days and ways", and using skills at the Senior Center that they remember from family times. Mr. Art Kavansu, retired, a naturalized American citizen from Mexico who now serves as a Resource Aid on the San Jose Council on Aging, suggested that to honor senior citizens they should be given title to small pieces of garden land to show appreciation for what they have done with their lives. In San Jose the Park Department divided 5 acres among 150 elderly families, where all nationalities now garden together without discrimination.

Improved service to minority elderly depends on the recognition of their special needs. In designing an ethnic service delivery system, factors to consider include:

MEDICAL:

(1) Assessment of the health needs of elderly minority members as *they* express them. Recognize the importance of folk medicine.

(2) Identification of coping strategies the minority elderly use to survive without institutionalization and determine their

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needs in relation to these.

(3) Identification of available supportive services and coordinate these services to meet the actual needs of the ethnic minority.

SOCIAL:

(1) Determination of their perceptions of their present life circumstances. Do they see themselves as productive, for example.

(2) Determination of their past experiences with supportive systems such as community health agencies, HDM, RSVP, the Church, and how this will shape their future use of services.

(3) Exploration of family ties, the frequency and extent of interaction with family members, as well as interaction with non-family.

After these factors have been determined, design a service delivery system unique to that ethnic group, building on the strengths discovered, and compensating for the weaknesses observed in support systems of the ethnic elderly.

IN THE RURAL AREAS— CAN WE DELIVER?

Coordinator: Roberto A. Mondragon, Dir., State Commission on Aging, Santa Fe, NM.

Resource Persons: Ronald Brambilla, Dir., Area Agency on Aging, Flagstaff, AZ; Rebecca Bustamante, Coord., Asociacion Nacional Pro Personas Mayores, Albuquerque, NM; Manuel Esquibel, Dir., District VII Area Agency on Aging, Pueblo, CO; Joseph B. Mann, M.S.W., Assoc. Prof., & Gary Means, D.S.W., Assoc. Prof., School of Social Work, Arizona State Univ., Tempe; Grover Payne, Coord., Rural Mobile Health Prog., Tucumcari, NM; Audrey Rose, Sr. Services Coord., North West Rural Resources Dev. Corp., Colville, WA; Charles Rupp, Exec. Dir., Community Services of Colorado West, Grand Junction; Bessie Smith, Navajo Rep., Advisory Council, New Mexico Commission on Aging, Shiprock; David Van Dyk, Research Asst., School of Social Work, Arizona State Univ., Tempe.

Paper Presentation: "Reaching Out to the Rural Elderly—Services to Rural America" by Gary E. Means, D.S.W., Joseph Mann, M.S.W. and David Van Dyk

The rural elderly face many barriers to their utilization of human services, not the least of which is the shortage of available services. Although this shortage is of critical importance, a concern of equal magnitude is that of the barriers to utilization encountered by the elderly in relation to existing services.

Factors which interfere with the elderly's desire or ability to utilize the available resources may be conceptualized as being utilization barriers. Although there may be a wide range of potential "barriers" to service utilization, viewing the elderly as "consumers" suggests the need to examine the individual "consumers" perception of barriers. Therefore, this study will examine barriers as the elderly from a rural area of Arizona perceived them.

In order to explore how these barriers effected service utilization, a series of tables will be exhibited and analyzed. Both objective and subjective data will be presented in order to solve the riddle of service non-utilization.

The data that is presented is based upon the survey responses of 122 randomly selected non-institutionalized persons over the age of 60. These respondents resided in two rural counties in the state of Arizona, Pinal and Gila counties. The survey was conducted in October to December, 1975.

Knowledge, or lack of knowledge of available services, may be a primary barrier. If a person does not know of the existence of a service, he or she will not be able to make a choice about seeking the service. In order to answer this question, each respondent was asked if they had heard of each of the twenty-two selected social services and programs. The average knowledge of the selected services was very low. An average of 42.7% of the elderly were knowledgeable of the services, while an average of 57.3% had no knowledge of the services.

The first table to be presented contains data given by the rural elderly as to why they did not utilize the limited available resources. The table presents a summary of the major categories of barrier areas which the elderly identified in response to the question, "If you need this service, what is the major reason you are not using the service?"

Table 1

Reasons Given by the Rural Elderly
For Not Utilizing Services

Transportation	Ill-Health	Self-Identity
50.0%	31.3%	18.7%

From an examination of Table 1, it can be observed that transportation was the major perceived barrier in the rural area (50%). For this table, "transportation" refers to problems in getting to and from the social service agencies. For many of the rural elderly, the services that were essential for solving problems may have been literally inassessable. Many rural elderly also reported that their personal health interfered with the consuming problem solving resources. This is indicated by the responses from 31.3% of the elderly in the rural area who said that their health barred them from using the resources available to aid them in problem solving.

The third factor which the rural elderly expressed as a barrier to service utilization was their personal self-identity. This is the issue of the elderly's pride and cultural norms and values. After providing for their own needs and solving their own problems, many elderly in the rural region (18.7%) reported that not seeking out assistance was a matter of preserving their self-identity.

To gain a greater understanding of these barriers, individual tables dealing with the barriers will be presented. These tables will present data concerned with transportation, health, and self-identification related issues.

Table 2

Transportation Modes of the Rural Elderly*

(What means of transportation
do you use most often?)

Respondent Drives	61.7%
Spouse Drives	7.5
Family Drives	22.5
Bus	.8
Taxi	.8
Walking	5.0
Other	1.7

*Taken from Means, Mann, 1976.

Table 2 indicates the percentages of the elderly population in the rural area who could not provide their own transportation and must depend upon others. It can be observed that in the rural area, 38.3% of the elderly population studied was unable to personally provide for their own transportation needs. These rural elderly were without the problem solving asset of personal transportation. This is especially critical due to the paucity of public transportation in most rural areas. This absence of mobility may force these rural elderly into a position where they cannot utilize available resources even if they exist.

It has been demonstrated that lack of transportation may be associated with an interference in utilization of services. The elderly's health may also be considered a substantial utilization barrier. If an elderly individual's health is "poor", this may restrict their movements and bar them from seeking out available resources.

Table 3

Health Status of the Rural Elderly

(In general, would you
say your health is:)*

Very Good	18.9%
Good	29.5
Fair	38.5
Poor	7.4
Very Poor	4.1
No response	1.6

*From Means, Mann, 1976.

Table 3 indicates that "poor" health effected an imposing segment of the rural elderly population studied. In the rural area, 12% of the elderly considered their health to be either "poor" or "very poor". However, the limitations in seeking out services is not isolated to those with "poor" health. The elderly individual may perceive their health as "good" but still health problems may effect their ability to be consumers of problem solving resources.

Table 4

How far would you say you
can walk without tiring?

3 miles +	15.6%
1-3 miles	32.8
Less than 1 mile	47.5
No response	4.7

An oservation of Table 4 reveals that a majority of the rural elderly may be restricted in their ability to physically seek out problem solving resources especially with limited transportation available. The data reveals that 47.5% of the rural elderly were unable to walk one mile. This lack of physical stamina may force some elderly to restrict their physical mobility in their environment, thus further restricting their ability to utilize available services.

The barrier categorized as self-identity and cultural norms and values is one which is difficult to concisely focus upon. This category of responses generally had to do with personal feelings toward a particular service and is exemplified by comments such as "I've too much pride", or "Who cares about old folks".

To aid in appreciating the elderly's impressions of "self-identity", two tables will be presented and analyzed. Self-identity is more than just the elderly individual's conception of himself; it also relates to the perceptions he feels others have for him. If the elderly individual feels that others view him as being less than a citizen and without rights, he will view himself in that same manner. To focus on this issue, the first table presents data on how the elderly individuals studied viewed their peers.

Table 5

Perceptions of Elderly Individuals
Held by the Rural Elderly

	Agree	Disagree	Depends
1. Most older people are annoying	11.9%	63.6%	24.5%
2. The secret to successful old age is to take life easy and relax	45.6	36.8	17.6
3. Older people are Valuable because of their experience	79.7	2.5	17.8
4. Older people not useful to themselves or others	6.0	72.4	21.6

An examination of Table 5 reveals that many elderly were ambivalent about their peers. For example, 24.5% of the rural elderly studied responded to the statement "most elderly people are annoying" that it "depends". The interesting facet of this response pattern is its ambiguity toward other elderly individuals; they may or may not be annoying. This is an indication that the elderly may feel that they are annoying to others and this conscience feeling may keep them from aggressively seeking out problem solving resources. The next table to be presented contains data on the elderly's perceptions of their own self-image.

Table 6

Self Image of the Elderly

	Quite Often	Some times	Hardly Ever
1. Do you feel that things keep getting worse as you get older?	16.7%	17.6%	65.7%
2. As you get older, do you feel less useful?	14.0	33.3	52.7

Table 6 demonstrates that the rural elderly individuals studied did not possess a productive self-image. This absence of a positive self-image may bar the rural elderly individual from consuming problem solving resources. The response pattern to the question, "As you get older, do you feel less useful," indicates that over one third of the elderly in the rural area said they "quite often or sometimes" did not feel useful. The elderly's apparent difficulty in maintaining a positive self-identity in an atmosphere where they are identified as being less than citizens may put constraints on their being active citizen consumers of problem solving resources.

SUMMARY AND CONCLUSIONS: This study has presented data on barriers which obstruct the elderly from consuming problem solving resources. The elderly population in the rural area reported they felt there were three major barriers to service utilization; 1) transportation, 2) poor health, and 3) self-identity.

The three barriers were analyzed with the use of supportive data to demonstrate the individuals effected by these barriers. The analysis revealed that roughly one third of the elderly individuals in the rural area may be barred from consuming problem solving resources due to lack of personal transportation and poor health which will not allow them to use the resource. A major barrier may well be the high percentage who had no knowledge of services available.

This paper on barriers was exploratory in nature. The barriers analyzed and discussed were the elderly's perceptions of why they did not consume services they needed. Although empirical study will be needed before the effects of barriers to service utilization can be fully understood, several implications are evident.

This study has found that a significant percentage of the elderly are not aware that many of the social service agencies even exist. This lack of awareness about the available problem solving resources is a paramount barrier which limits the elderly consumer in the selection of needed services. The significant point here is that present information dissemination channels are not adequately meeting their objectives. Much more use of the media should be made in informing the elderly of services, especially the newspapers.

Even the most audible and diverse system of communications may not be able to insure that those elderly who need the service will consume it. For the elderly consumers have reported the existance of barriers which actively interfere with service utilization. To reach past these barriers, to the elderly consumers, should be the responsibility of the service providers. This may require a constant and aggressive outreach program to get the service out to the rural elderly as well as the development of more adequate transportation systems. It might be well to consider taking the service to the elderly instead of making them travel long arduous distances to the service. This latter approach, even with a well developed transportation system, might well be a major barrier to service utilization. These programs should be designed to construct passages of hope through the barbed barriers of isolation.

With the application of these multi-dimensional communication and outreach systems on a continuous basis, the service providers may take the first step in treating the elderly as citizen consumers and not as custodial clients or patients. It should be the responsibility of the area agencies to coordinate the combination of outreach and communication systems. Along with the development of these applied systems, the Area Agencies on Aging might also develop a comprehensive program of studying, implementing, and evaluating their communication and outreach systems.

Can we deliver services to rural America? This question may be mute in its first analysis, however, it is not "can we" but how do we. A system of communication must be developed with the elderly in mind. But communication systems are only a start, aggressive outreach programs must be developed to reach beyond the barriers of distance and scarcity. The rural elderly have been expected to reach out to the service delivery system, now is the time for this system to reach out to the rural elderly.

COUNSELING: A TECHNOLOGY OR A HUMAN SERVICE?

Coordinator: Arthur N. Schwartz, Ph.D., Dir., Adult Counseling Prof., Andrus Gerontology Ctr., USC, Los Angeles, CA.

Resource Persons: Rosalyn Benitez, D.S.W., Assoc. Dir., Jewish Family Service, Los Angeles, CA; Dorothy Fleisher, Doctoral Candidate, and Barbara Kaplan, Doctoral Candidate, School of Social Work, USC, Los Angeles, CA; Selma Zarakov, Coord., Prog. for Older Adults, Palomar College, San Marcos, CA.

Paper Presentation by Dorothy Fleisher and Barbara Kaplan.

Before we discuss where, how and to whom we wish to provide counselling services, I should like to review some aspects of the common background shared by our present older generation. For after all, it is this kind of knowledge that will influence how we structure the delivery of services for this generation.

Who are the people for whom we are designing services?

Think for a moment of the kind of world, a person who is 85 years of age today, was born into. Born in 1892, and having lived through the myriad changes, technological and social, must certainly have demanded great flexibility and coping ability, to survive to the present. Today, 11% of the population, about 23 million persons, are 65 years of age and over. Born in 1912, or earlier, they evolved their philosophy and values based on quite a different historical experience, than most of us in this room have known. Their dream was to become the self-made person, the small farmer, the independent businessman, the craftsman, or artisan. Independence was the goal...and it was a social stigma to seek help outside the family.

The human services that we accept as part of our daily lives were not part of their growing up experience. The programs of the 1930's, during the depression...Home Relief, Wpa, Pwa, CCC, were seen as temporary stopgaps to help people through a national period of emergency.

after all, Social Security was not passed until 1936, and it is only 12 years since Medicare and Medicaid went into effect. The Older Americans Act, which has been the harbinger of service programs for older persons, did not have funds allocated to carry out its mandate until 1970...only 7 years ago.

Thus, for most older persons, help of any kind was seen as primarily the responsibility of family members, relatives and lifelong friends.

Another phenomenon, requiring careful consideration when determining the best means of delivering counselling services to our elderly, *is the changing structure of the family*. The mobility that began during WWII, with the need for manpower in defense industries, and in the armed forces, continued after WWII, and resulted in family members and relatives being spread out from coast to coast. This served to reduce the number of persons available to help and support older parents and relatives. (This continues with the decreasing number of children born.)

The number of men killed in the constant succession of wars, WWII, Korea, Vietnam, have also seriously reduced the number of relatives available to the older person.

The population shift to the suburbs, with older persons remaining behind in the inner cities or older communities, and with services moving to the new communities which could finance them...left its impact as well.

Another consideration is the increase *in life expectancy* for infants and children. This means that more people are living, and thus reaching old age than ever before. What is occurring as a result, is that persons, themselves considered old, are seeking help for their parents, and seeking out services that can aid them in exploring viable alternatives for them and their parents.

Added to these commonly shared experiences, we recognize that individuals may have physical limitations, or need help in coping with environmental problems on a day to day basis. In addition, to inter or intra-personal problems that may be needing attention, these other areas may also be influencing their psychological well-being.

Thus we see, that the persons for whom we are designing services, are 95% of the 23 million persons, 65 years of age or over, who live in normal communities...NOT IN INSTITUTIONS...and they depend upon community services for their daily needs.

Therefore, because of the values that they hold, and the newness of their experience with human services, we must design systems in such a way that the dignity and autonomy of the older person is preserved. When services are constructed as permanent features of society, like public education, or public libraries, then people become accustomed to their existence and are encouraged to use them. However, if services are provided on a temporary basis, and only to those in need, there is reluctance to identify oneself as dependent and to be stigmatized by using them.

HOW ARE WE TO DESIGN OUR COUNSELLING SERVICES? IF WE AGREE WITH THIS PERSPECTIVE,

1. Services should be community-based..where the elderly live, and preferably where they can be within walking distance...or if necessary not have to take more than one bus to get there. That means services must be placed in communities in which older persons tend to congregate.
2. Services must be accessible...with a minimum of physical barriers such as steps, elevators. Preferably to be located on a street level rather than in an office building...which looks like a catacomb, to many elderly persons.
3. The service center should be visible. That is, it should be as much a part of the neighborhood as the local grocery, bakery, butcher shop or fish store. It must be part of one's daily life...so that when the need arises it is not an unfamiliar place, and does not represent a threatening environment that must be entered.
4. It should not imitate the medical model of services, with a waiting room, closed cubby holes, doors which open and shut as though all who enter have serious, secret, social illnesses and problems that require consideration out of the sight of one's neighbors. (This is not to say that there are not circumstances and situations that may require privacy...but most do not.)
5. An open floor plan, where all activity is visible carries the message that these goings-on concern the everyday stuff of daily life...and that everyone experiences the need for help in different times. It is o.k. to see your neighbor there, in fact that may be how you knew it was(the place to go to for help.
6. Services should be offered on a walk-in basis. This encourages the use of services when the need arises...knowing that immediate attention will be given and a service rendered as quickly as feasible.
7. The atmosphere should be warm, friendly and homelike rather than sterile, impersonal, and oblivious to the concern being felt by the older person or family member. Coffee, tea, cake, should be available to help comfort and relax persons who may have to wait their turn.

Having outlined how we might wish to design our delivery system we turn now to deciding *WHAT SERVICES ARE TO BE OFFERED.*

To be considered a human service, counselling must be related to the needs of the whole person.

Whether the request for service is for aid in coping with the environment or for personal counselling, we recognize that psychological implications are inherent which will influence one's ability to function. Therefore, no request is too small...or too large.

It may require:

a. filling out a form for medicare
b. making a phone call about a delinquent payment
c. providing transportation for a medical appointment or a visit to a spouse or friend in an institution
d. Or perhaps what is needed is intervention with a public agency or private enterprise on behalf of or with the older person
e. The service requested may be for help to establish new relationships to replace those lost.

2. Help with inter and intra-personal problems may involve:
    a. Counselling for depression stemming from loneliness or prolonged grief over the loss of a spouse, sibling or lifetime friend.
    b. Or the depression may stem from the inability to adjust to retirement with its destruction of the structure of one's daily existence for 40 years.
    c. It may require helping a person become involved in a community organization as a means of restoring a sense of belonging and meaningfulness to one's life.
    d. Sometimes it means helping older persons to form advocacy groups on their own behalf...working to convert the community into a viable and safe place for older persons.This may involve adjusting the timing on traffic lights,organizingnutrition programs, working on rent rebates, or benches for the area.

No matter which of the services is proposed, as appropriate for the individual being counselled, what is clear is that these services must be made available if we are to truly view the whole person as our responsibility.

3. The range of services to be offered must be expanded to include opportunities that go beyond the one-to-one helping relationship to include:
    a. Self-help...such as participation in community organizations and advocacy groups.
    b. Mutual help...opportunities to meet with peers and discuss and share problems.
    c. Counselling services must be structured to include within their system a place for a donor-recipient role. That is...the ability to move back and forth between being a donor of services at one time and in some areas, to being a recipient of services when the need arises. This must occur without any stigma or discrimination attached to the need to change roles as the situation demand.

Thus we see that whom we serve, how we structure our delivery system and what we include as counselling services, are inter-related and stem from our personal philosophy of what we perceive as the needs of older persons. I don't believe we can separate the administration of our service from these considerations...nor can we declare that is our philosophy without carrying out administratively the responsibilities inherent in such a declaration.

Our task this afternoon is to explore the aspects of counseling that involve providing information and referral about community resources. Too often, we have underestimated the skills involved in providing this service. We tend to see it as the least demanding aspect of counseling. In part, this stems from a mistaken assumption that persons requesting information are able to clearly identify not only their needs, but know the type of service which would be available to respond to these needs as well. However, in reality, providing proper information and appropriate referral is a very complex, demanding responsibility in which workers are called upon to use every bit of their understanding of human behavior, their knowledge of community resources, and their counseling skills. For what usually occurs, is that the person requesting information can not clearly express his need and so talks on, hoping that the worker will be able to identify the problem and suggest the appropriate community service. The importance of utilizing a highly skilled worker to provide information and referral becomes evident when we realize that for most people it is their entry point into the service delivery system. If this first contact results in failure, they will not return.

What I'd like to do now is demonstrate through role playing what usually happens when a person requests information. I'd like you all to be watching for what the worker does *wrong* and after the skit, we can share our observations.

Skit One: Person makes straightforward request for names of board and care homes.

Worker responds with a series of probing questions...

Person states..look, if you don't want to give me the information, that's okay, and hangs up.

Debriefing: What did you see?

Skit Two: Person is obviously upset..voice wavery..asks for names of board and care homes.

Worker responds with questions as to where person lives..then proceeds to give a list of names.

Debriefing: What did you see?

Skit Three: Person is obviously upset..asks for names.

Worker responds correctly..acknowledges upset..invites person in.

Debriefing: What did you see?

Purpose...focus on clues used in making correct decision re: component of information and referral..info only; referral; counselling.

Let us now examine in more depth what is involved in providing information and referral.

The information component of the service involves informg the person as to the existence of a community resource about which he wishes to know. It is a straightforward service. Yet here, too, the worker's skill is called into play. For example, in order to adequately answer the request, "Where do I go for a flu shot?", a worker would need to know where the person lived, the name, address and phone number of the nearest clinic providing the shot, the person to contact, the hours the clinic is open, the fee schedule, and any special information the person might be requested to provide, such as his doctor's name or history of allergic reactions. However, what too often occurs, is that the worker is not prepared with this necessary information, and becomes impatient with the person's questions.

Referral, on the other hand, involves the worker on another level. Using his skills to understand the situation, the worker determines that the person required more help than just information. Not only does the worker give the person the name of an appropriate agency, he may initiate contact with the agency, as well as follow-up to see that the request has been handled. For example, a person asks for information about food stamps. In talking with him, the worker learns that the person has already contacted the Department of Social Services, and has been told something he didn't understand. The worker may act by calling the Department of Social Services directly. And if a visit to their office is necessary, the worker may accompany the person. To facilitate the request, the worker has an established relationship with one person in the other office. Finally, in completing the referral process, the worker may call back the person requesting information to check if he did indeed receive food stamps. If not, the worker would inquire as to whether he was managing on his limited budget.

Counselling involves still additional skills of the worker, again based on an assessment of the person's ability to function.

For example, a person calls on behalf of her mother requesting the name of recreation centers. In speaking with the daughter, the worker learns that her father has died a month ago and her mother is constantly crying and refusing to socialize with anyone. Thus, what appeared to be a call for information is evaluated by the worker as requiring a different level of intervention. The worker is aware of the mothers need to mourn as well as the daughter's anxiety. The worker suggests to the daughter that she come in as she appears to be suffering and carrying a great deal of responsibility in the situation. Having differentiated among these three components—information, referral, and counseling—now let us examine what clues we use in making an assessment as to the appropriate service to provide.

First, it is important to understand what is involved in a person's decision to call a service agency. As Barbara pointed out earlier, because of the value of independence among the older people in our society, many persons have the feeling that to take help is to admit failure. Thus, a person may have to experience great stress to initiate the first call for help. Sometimes a peson may be in a crisis situation. He may sound extremely upset and confused as his usual ways of handling problem situations may not be working. From crisis theory we know that the outcome of a crisis in an individual's life largely depends on the help immediately available when the crisis occurs. If help is not forthcoming, if the need for counseling rather than information is not recognized, or if the person is shuttled from agency to agency, or worker to worker, he may become discouraged, and give up.

Second, we need to consider the content of the person's request. For example, if information is asked about board and care homes, we need to become immediately alerted because this type of situation invariably required more than just information because of the inter and intra personal relationships involved. Or, if the request is related to how to replace a lost social security or gold check, we should be listening carefully as well. Perhaps this presents a crisis for the individual. As it is a loss, it may be emotionally upsetting and/or economically disasterous, especially if the person has no other source of funds to tide him over until his check is replaced.

Third, we need to go beyond hearing the content of the request to listening with a third ear for the underlying emotional tone in assessing the situation. If the request for information is made by telephone, we listen to the sound of the voice. Is it weak or strong? Is the person's request garbled or clearly formulated? Does the person sound upset, as if he had been crying recently; or agitated, hurridly switching topics; or depressed, speaking in a flat, monotone. If the request for information is made by the person directly, in a face-to-face interview, we rely on non-verbal cues as well in assessing the emotional state. We observe the position of his body, and the way he moves his hands. Does he appear restless, distracted? Is he making eye contact? Is he crying, or in obvious pain? We use this information, gathered within the first few minutes of the interview, in assessing which level of intervention is required..information, referral, or counseling.

Now, lets us consider another aspect fo the worker's responsibility which we have not yet explored. The worker must document what the areas are in which no community resources exist to respond to requests for services as well as the numbers of persons affected by this situation. And the worker must share this information with appropriate agency staff and community groups so that additional programs can be developed. One worker successfully used the information she had gathered over several months to encourage her agency to develop a homemaker service which was needed, but not available.

Linking individual needs with community resources required the utmost skill. The challenge facing us is to acknowledge the complexities of this task and to prepare the workers who are to be assigned this responsibility.

COMMUNICATIONS AND THE MEDIA

USING COMMUNICATIONS TECHNOLOGY: GETTING TOGETHER ELECTRONICALLY

Coordinators: Ben Park, Ph.D., Dir., Communications Research, Alternate Media Ctr., New York Univ. Reading Consortium, NY & Bill Sacks, Ph.D., Applications Consultant, Comshare, Los Angeles, CA.

Resource Person: Tora Kay Bikson, Ph.D., Research Psychologist, Rand/Spartanburg Telecommunications Project, New York City, NY.

Recorder: Bob Vollmer, Student, Univ. of Utah, Salt Lake City.

The key words here are interactive television—T.V. in which senior citizen members of the T.V. audience carry on two-way communications with persons at the television station and with other senior citizens at other locations.

Elderly men and women in Reading, Pennsylvania and Spartanburg, South Carolina interact with others on a regularly scheduled basis—using present-day communications technology. Utilizing another facet of communications technology, computer specialists are developing ways that older Americans in the future may take advantage, over long-distance telephone lines, of opportunities afforded by electronic computers at distant locations.

In Reading, older men and women participate daily in social services communications programs in which their senior citizen center receives and transmits T.V. sights and sounds between the center and the community T.V. station—which, in turn, is linked with 38,000 home T.V. outlets in the community. A demonstration (via videotape) showed senior citizens in live T.V. give-and-take discussion with their mayor. The mayor was in his office in City Hall. The seniors were at their enter. They both saw and heard each other by means of T.V. split-screen presentations. The demonstration was given by Ben Park.

In Spartanburg, a four-point electronic hook-up enables participants at three centers to interact live with each other and with a program coordinator at the television studio. Programs can originate at any one of the points and be seen and heard by those located at the other three locations. A videotape showed segments of Perspectives on Aging, an information/education social services program that was, at that time, in its second month. This demonstration was given by Tora Kay Bikson.

Using a computer terminal keyboard set up in the Denver Hilton and linked by long-distance telephone lines with a computer in Ann Arbor, Michigan, a demonstration showed how a computer set-up can be used to provide the elderly with social services information and education which they specifically request via the computer terminal keyboard. The senior (or someone acting for him or her) makes a request of the computer—and the answer from the computer lights up the computer terminal display screen instantaneously. The information that can be stored in the computer's memory bank is, for all practical purposes, limited only by man's imagination. This segment of the three-phase communications technology program was presented by William Sacks.

COMMUNICATING AND USING RESEARCH INFORMATION

Coordinator: Raymond M. Steinberg, D.S.W., Proj. Dir., Research Dissemination and Utilization, Social Policy Lab, Andrus Gerontology Ctr., USC, Los Angeles, CA.

Resource Persons: Elias S. Cohen, M.P.A., J.D., Editor-in-Chief, The Gerontologist and Proj. Dir., Law, Aging & Long Term Care, Public Interest Law Ctr., Philadelphia, PA.; Neal E. Cutler, Ph.D., Chief, Social Policy Lab, Andrus Gerontology Ctr., USC, Los Angeles, CA; Carroll L. Estes, Ph.D., Principal Investigator, Project IDEA, Dept. of Social & Behavioral Science, Univ. of Calif., San Francisco; Michael Israel, Tony Mindlin & Deborah Newquist, Andrus Gerontology Ctr., USC, Los Angeles, CA.; Fernando Torres-Gil, Ph.D., Dir., Research Dissemination and Utilization, Social Organization and Behavior Lab, Andrus Gerontology Ctr., USC, Los Angeles, CA.

Recorder: Mary Shenefield, Executive Secretary, Wyoming Senior Citizens, Inc., Riverton.

Innovative projects which are attempting to make current research findings accessible to and utilized by community leaders, policymakers and practitioners who are advocating, planning, or delivering services to the elderly were discussed by the resource persons. Dr. Steinberg organized the workshop around clarifying the problems of dissemination, what has been found to deal with the problem, and what directions to take.

Michael Israel wants to change the way researchers package what they say and how users use it. Preliminary data in his findings to date indicate no significant differences in the usefulness of research reports based upon individual readers' differences of professional identity, academic attainment, or years of work experience. When people were asked, "What makes the difference between the research reports which you read and which you don't read?," 93% commented on CONTENTS, 29% referred to FORMAT, 19% cited problems of available time, and 14% included comments on the PROCESS. Readability is yet another factor to consider. Among the implications of the study to date are (1) Those who requested research reports were most likely to read them, (2) Those with national leadership roles were most likely to find that kind of study useful, (3) Those who participated in the research project were more likely to read and obtain benefits from the findings than those who did not participate, (4) Many people at the AAA level have not had positive experiences with job-relevant social research; therefore, in addition to having justified criticisms, many hold self-fulfilling negative stereotypes about the potential utility of AoA-funded policy research, and (5) To the extent that greater interest and utilization of research is to be achieved at the practitioner level, research questions need to be relevant to problems in practice, and findings must be presented in an applicable, brief and readable manner.

Tony Mindlin explained what he feels makes for receptivity of research findings; that is, disseminate in the language of the user. Researchers have to help practitioners interpret data as it is now. Because the aging network and Title IV network are not tied together, agencies have little or no input into the Title IV projects.

Ms. Estes spoke about the information needs of legislative bodies and how Project IDEA came into being. A telephone survey is being conducted to find the key and to answer the question, "Has information interface increased?"

Mr. Torres-Gil explained the ambitious five-year program that conducted research in areas where little information is available and examined the implications for social policy of the various social and cultural contexts of aging. The results are accessible to legislators and other policymakers who can best use the findings at local, state, and national levels. "Academic studies, no matter how accomplished, often remain in the confines of the university or at best are communicated to colleagues on other campuses," reported Mr. Torres-Gil. In addition to organizing gerontological seminars and presenting research papers at academic meetings, there has been a determined effort in this project to focus upon work *within* the community itself. This is reflected in the continuing involvement of a representative Community Research Planning Committee to facilitate the adaptation of research findings into significant policy recommendations. The *use* of findings is most important.

Deborah Newquist underscored such dissemination goals in her presentation. The researcher has to make sure that the information goes beyond the university setting to policymakers, advocates, practitioners, etc. She explained the strategy of defining target audiences (national, state and local decision-makers, community persons, and academicians) and matching the deliverables (written materials, audio-visual/media, and personal contact) to the target audiences. How to meet the need on State of the Art, how to impact on policy (change) and how to be sensitive to community needs yet develop sound research are other considerations of their social organization and behavior laboratory. Useful handouts, "Decisionmaker Survey Report" and "Community Survey Report" were distributed.

Neal Cutler clarified the difference between dissemination and utilization. Although Elias Cohen had interjected thoughts during each presentation, he concluded the workshop with his thought of how stimulating meetings such as this can be by pushing the participants into new thoughts and permitting our batteries to be recharged.

BASIC RELATIONS FOR SOCIAL SERVICE AGENCIES: GETTING YOUR MESSAGE ACROSS

Coordinator: Kathleen E. Kenny, Co-Chairperson, WGS Public Relations Committee, Center on Aging, School of Social Work, San Diego State Univ., CA.

Resource Persons: Steve Brummell, Exec. Dir., The Elvirita Lewis Foundation, Santa Cruz, CA; Charlotte Leigh-Taylor, Communications Consultant and Information and Referral Specialist, Tri-County Area Agency on Aging, Santa Barbara, CA.

Recorder: Mary Shenefield, Executive Secretary, Wyoming Senior Citiznes, Riverton, WY.

Charlotte Leigh-Taylor defined Public Relations as "creative communication," but added that there are broader implications. "What you *are* speaks so loudly I can't hear what you say." Basic media includes feature stories, radio spots, news stories, documentaries, films, press conferences. Supplementary devices include newsletters, letters of appeal, slide shows, posters, brochures, etc.

Steve Brummell gave an insider's view of how to use existing mass media. The newsman's problems must be understood - the news business *is* business. He advised against holding news conferences since generally what is to be conveyed can be said in a news release. Moreover, press conferences are for persons who already have a constituency. He suggested developing personal contacts and employing friendship. News is "change - unusual occurances -those things which affect many."

CONTENT

1. Releases should stick to a lead paragraph that gives the WHO, WHAT, WHEN, WHERE, WHY, and HOW of a story. Give as many facts as possible in the first two paragraphs using pyramid development - most important to least important.
2. Release does not have to be limited to two paragraphs. Following paragraphs can include pertinent information. This arrangement of details allows the editor to choose information for available space.
3. Releases should use short, declarative sentences and good manner. An AP Style Book is helpful, but the writer should try to slant his style to that of the newspaper.
4. News items should not be attributed to an officer of the organization in the lead. Attribution should be avoided unless the person has a quote of wide interest.
5. Releases using *today, yesterday, or tomorrow* should have the day and date in parenthesis following.
6. Avoid superlatives, adjectives and other forms of editorializing.

PRESENTATION

1. Use 8½ x 11 *plain* paper (letterhead may be used if in good taste).
2. Develop news release head - attractive, distinctive, but not gaudy.
3. Double space all releases and use only one side of paper.
4. Do not use solid caps in a release and leave ample margins for editing.

5. Below heading, type in the name of a press contact with telephone number.
6. If longer than one page, put the word "more" at the bottom of page. At the end of the story type ####.
7. Leave a wide margin between the headline and the story so the editor can put in his own headline if he desires.
8. Send out all news releases to all newspapers at the same time.
9. Pictures may be included, but should have action, should have cut line to identify persons left to right, should be clear and distinctive.

DO'S AND DONT'S

1. Don't push to find out why a story wasn't printed.
2. Don't ask for a tear sheet or to see galleys.
3. Don't send a release too far in advance and expect it to be held.
4. Don't tell an editor why a story is important.
5. Do know the story you are sending is the type used in the media to which it is being submitted.
6. Do know the correct name and title of the editor and use it.
7. Do be truthful. Don't claim a promotion as news or downgrade opposition or distort facts.

Attaching a checklist to the file copy of the release will help in verifying where the story was sent. Follow up to see how many releases are printed and how they are printed is a good procedure also. Developing a photo file and a resource file were other suggestions to the PR person.

Public Service campaigns for radio and television were discussed by Kathy Kenny. The following questions should be answered affirmatively:

1. Are your facts accurate?
2. Do you use full names in your copy and is the spelling of names dependable?
3. Are you careful about spelling out dates, times, and places so there can be no mistake?
4. Do you avoid using pressure and nagging tactics on editors and program directors?
5. Do you give all media an equal break on news releases you originate?
6. When one medium originates an "exclusive" in which you are involved, do you protect that "exclusive"?

An effective public service appeal will deal with (1) WHAT is the message, (2) HOW best to carry the message to the public, and (3) WHO should receive the message.

Concerns of courtesy indicate the necessity for cooperation with the station, also. Appointments should be made in advance with the Program Director. Punctuality at the appointment and preparation with the basic "WHAT-HOW-WHO" are important. Following the suggestions of the station experts who are trying to help is useful. Knowing your limitations and using your own organization as a promotional aid will also enhance the success of your campaign.

Either programs or announcements can be employed for public service material. Keeping in mind the time limitations of the station, the message and potential audience will dictate the format. A special word of warning regarding TV involves planning for both audio and visual to avoid the talking face.

I DANCED AT MY WEDDING

by Clinton Hess, Director, Office on Aging, Region VIII, Denver, CO.

I danced at my wedding.

A violin
  sang and sighed
  laughed and cried.
The melody to which I danced
  was not from the violin.
I danced to a counter melody
  swells and stacatos
  crescendos
  pianissimos
  rising from the depths of my years
    my four score and nine.
The melody to which I danced
  was composed
    by my love of life
  and the excitement
    of each new day.

I danced at my wedding.

A drum
  marched and rolled
  for young and old.
The rhythm to which I danced
  was not from the drum.
I danced to my heartbeat
  days and nights
  weeks
  months
  the seasons
  playing from the depths of my years
    my four score and nine.
The rhythm to which I danced
  was measured
    by the passion
  and the sounds
    of God's metronome.

I danced at my wedding.

The step I danced
  was without name.
No one had done it before.
No one will do it again.
The twirls
  the leaps
  the pounding of my boots
    on oak
  were mine and only mine.

SPECIAL INTEREST SESSIONS

HOSPICE PROGRAMS

Coordinator: Theodore H. Koff, Ed.D., Assoc. Prof., Retirement Housing Admin., Univ. of Arizona, Tucson.

Resource Persons: Kit Grady, Dir. of Community Development, Hillhaven Hospice, Tucson, AZ; William Reed, F.A.I.A., Harris, Reed and Litzenberger Architects, Tacoma, WA.

Recorder: Christine Stumpf, Student, Univ. of Southern California, Los Angeles.

Webster: Hospice — 1. a place of refuge for travelers, especially that belonging to the monks of Saint Bernard in the Alps. 2. a home for the sick or poor

THE TUCSON STORY

A man's friend with terminal cancer was discharged from the hospital to die at home. The patient's spouse was a paraplegic and could not do what needed to be done. The man rallied support for his dying friend from friends in the community who gave physical assistance and psychological-loving support for the ex-patient and the disabled spouse. From this support group came the idea of a facility to care for the terminally ill, where comfort and dignity of the dying person was respected, and other family members were surrounded by supportive friends and community. The Hospice Program of England came to mind, and that of Saint Christophers, in particular. While England has a socialized medical plan, and establishing a hospice there is no great problem, in this country there was much ground-work to be done in educating the community to the desirability of a hospice and then to get financial support for building and staffing some. What follows is what a few Tucson citizens did to get their hospice.

ORGANIZING

Research the community and know what services are already provided.

Present your case for a Hospice in the community to community groups.

Enlist support of and integrate services of:

American Cancer Society - an Oncologist (cancer Specialist).

"Quality of Life" committees — have different names but stand for the same things.

City Officials — in rural areas — county and state representatives.

Medical Community — Medical centers and Hospitals.

Visiting Nurse Association.

Mental Health Agencies.

Volunteer Bureaus — ex-cancer patients, families of deceased cancer patients.

Various Religions' Family Services.

Government Agencies and Officials.

Involve:

The religious community to spread the good news.

Cancer Institute to gather information and statistics.

Women's Groups for volunteers.

High School health classes for volunteers.

If not profit making — associate with United Way.

Funding — one of the hardest jobs.

Publicity — grand and glorious Open House and make sure the news media is there.

GOALS

Primary Goals: Dignity and comfort of dying Patient.

Secondary Goals.

1) assist state legislature in defining and licensing Hospice as a separate facility from nursing homes or hospitals which are rehabilitative or restorative facilities.
2) provide internships for pharmacologists, nurses, social workers.
3) educate the public in the new concept of death and the dying, and the needs of the dying patients family.

THE PATIENT

Admittance to hospice comes when all treatment has failed. Whatever the patient wants or would make him/her comfortable is given.

Once admitted, Hospice will provide continual care and enable patient to live in comfort and as free from pain as medication will allow.

Small pets will be allowed if necessary.

Family members or friends may be with him/her any time of the day or night.

Cultural differences will be considered with each patient.

Patient's family provided with counseling services for a year following death.

HOSPICE STAFF

Nurses, Chaplain, Social Workers, Psychologist and Volunteers.

In dealing with death, staff needs to meet weekly to discuss problems of patients and of staff's psychological well being, and to warn of dangerous emotional involvement.

Clerical help needs sensitivity training to situation also.

Staff's families are hopefully oriented enough to understand strains of work.

Volunteers are needed to support people at home as well as sit and visit with patients.

HOSPICE COST

$60 per day as compared with $28.30 in a nursing home and $120 in a hospital.

HOSPICE FACILITY

Capacity is 39 beds, with daycare facilities to accomodate 10 more patients.

Physical plant is as homelike as possible.

Library, Chapel, Chaplain's Room, Viewing Room (for deceased), Nurses Lounge, Family Lounge, Room for eating together as a family, Activity Room.

Rooms accommodate two patients each.

Meal time - a choice menu and served at a convenient time.

Special food likes of patients will be kept on hand.

DIRECT YOUR QUESTIONS AND INQUIRIES TO:

Kit Grady, Hillhaven Hospice, 5504 E. Pima Street, Tucson, Arizona, 85712.

ORAL HISTORY: PRESERVING OUR PAST FOR POSTERITY

Coordinator: Gwen Safier, Ph.D., Gerontology Program, Holy Names College, Oakland, CA.

Resource Persons: Ralph J. Caro-Capolungo, Dir., RSVP Program, Laney Community College, Oakland, CA; Sara Harris, Vice-President, Center for the Study of Aging, Inc., Albany, NY; Ruth Hersh, Ph.D., Faculty, Fordham Univ., New York; Renee Goldsmith Kasinsky, Ph.D., Asst. Prof., Sociology, Utah State Univ., Logan; Lucile Lockhart, Gerontology Program, Holy Names College, Oakland, CA.

Recorder: Beverly Seeds Little, Graduate Student in Gerontology, Univ. of Southern California, Los Angeles.

Oral History dates back to the earliest years of man's communication with other men. At a time when there was no written language, it enabled men to keep in touch with happenings in the past. Oral history breaks down barriers and provides a connecting link between generations. Through the use of oral history, one can show the development of people and of social movements. Oral history might help an elderly person, who is isolated, find a reason for existence. It is valuable because it gives the interviewee a feeling of self-worth, and the interviewer gains an insight into the person and his past. Oral history may be recorded on tapes and stored for use by scholars.

Oral history may be used as a systematic and deliberate research tool, and should be a required clinical experience for doctors and psychologists who work with older people. It can be a valuable way of securing medical data as well as a therapeutic tool. It is thought that oral history might help a senile elderly person to recall recent events. It is possible that oral history could be used to help medical personnel differentiate between organic disease and mental problems.

Fordham University has been taping oral histories of people who have aged successfully. They have found it wise to use older people to interview the aged, for they share similar life experiences and know the questions to ask. In taking oral histories, it is important to record feelings as well as experiences. An awareness of body language—tension, depression, vitality, anger, signals, pauses—is important.

Professor Alan Nevins at Columbia University has been the recent innovator of oral history. His book, *Gateway to History* is a classic. The Oral History Organization which was formed in 1947 holds a yearly meeting. A few students have earned bachelor's degrees in oral history. There seems to be a constantly increasing interest in the field of oral history, as more and more people discover its potential for helping individuals and society.

EXPERIENCE OF A PHYSICIAN-NURSE PRACTITIONER TEAM IN CARE OF PATIENTS IN SKILLED NURSING FACILITIES

by Phillip M. Loeb, M.D.
Billie Joy Robison, R.N., F.N.P.
Fremont, California

The use of a physician-nurse practitioner team is advocated as an approach to delivering better health care to patients in skilled nursing facilities. The application of this approach in a young community with an inadequate supply of primary physicians and 596 extended care beds is discussed. Patients derive benefit from more comprehensive health care delivered with greater attention to individual needs. Staffs of skilled nursing facilities enjoy improved communication with the medical team and better compliance with legal requirements. The team physician is able to use his time more effectively and provide medical supervision for a greater number of patients by sharing responsibilities with a nurse practitioner.

Paper compliance, adherence to agency regulations, quality assurance, and payment are some of the problems encountered.

Fremont, California, a large suburban community in the San Francisco Bay Area, suffers, as do many similar communities, from a shortage of primary care physicians. Although the average age of Fremont's population is 25 years, the community has six skilled nursing facilities (SNFs) with 596 licensed beds, the majority of which are filled from outside the community. Most local physicians care only for SNF patients generated by their own practices. Many are too busy to accept new patients at all. This situation creates a problem for elderly patients who must have a physician of record before they can be admitted to a SNF. The result is that an administrator may call 15 or more doctors in attempting to find one who will accept a skilled nursing candidate as a patient.

I found myself no less besieged by SNF patients than were my colleagues. I continued to accept SNF patients even though doing so caused a number of problems. To avoid office-hour conflict, rounds were made before hours and on days off. The time pressures produced "jet-propelled" rounds and family conflicts. I often was unable to respond promptly to urgent calls at a SNF because I was swamped by younger patients whose problems were less profound, but whose rehabilitation potential seemed much greater. Gradually, it became clear that I was practicing two grades of medicine. My geriatric patients who could not come into the office received less than adequate care, although it was on a par with that generally provided for the SNF patient population. Considering the problem of geriatric medicine in the SNFs, I also felt uneasy that insufficient physician participation might provide a level for more rapid socialization of the private practice of medicine. I began searching for a way to meet the needs of the SNF patients while maintaining a full range family practice and my sanity.

It seemed sensible that a physician-nurse practitioner team approach could provide comparable basic medical care with greater attention to patients' total health requirements without a greater investment of physician time. The combination of the curing skills taught in traditional medical education and the caring skills taught in traditional nursing education, when combined in a SNF setting where the latter are often more appropriate than the former, might provide better care than had ever before been possible. The team concept was discussed with the physician members of a SNF utilization review committee who thought SNFs an excellent location in which to utilize the skills of a physician extender.

This paper will report the experience over a one-year period of a physician-nurse practitioner team which was formed in July, 1975.

Development of a Team Approach

On the date the family nurse practitioner (FNP) was to join me, I was providing a preceptorship for a Stanford physician's assistant (PA) student and had six weeks before completion of that commitment. The FNP used that time to familiarize herself with our convalescent hospital patients, key personnel, and the different hospital environments. She was able to do so under less pressure by not having to spend half her time in the office. During lunch hours, we reviewed her patient assessments and revised their form and content until they communicated what I needed to know about each patient. We also discussed patient problems during these sessions, which allowed me to assess the FNP's skills and progress in delivering patient care and investigating problems.

After the first six weeks, the FNP team member worked half time in the office seeing a full range of family practice patients. She assisted with complete histories and physical examinations and performed physical assessments for insurance, annual well checks, and sports, well-baby, and obstetric examinations. She also dealt with routine sick checks and made housecalls. My interaction with her in the office setting provided the opportunity to assess and augment her clinical knowledge, skills and judgment. That assessment and interaction provided the basis for the mutual trust and communication essential to work as a team when she was in the SNF and I was in the office. She functioned well in the SNF to the limits of her ability, confident that I was always available for immediate consultation and support.

Our care of each SNF patient began with the FNP performing an initial assessment and developing a problem list and an investigational work-up or therapeutic plan which I promptly reviewed with her. She also made required monthly evaluations and updated annual physicals for the SNF patients. It is in the areas of initial assessment and routine visits that the largest savings of physician time has accrued.

Her recommendations were accepted as telephone orders from me. A telephone order form for the accepted orders was then dispatched to me for prompt signature and return. I countersigned each of her progress notes and signed orders monthly for each patient.

The FNP also made emergency calls on any patient who had an acute problem between the scheduled monthly visits and was constantly available for phone consultation. Additional important savings of physician time and improvement in promptness of response to patient needs were realized here. She also talked frequently and at length with the families of SNF patients. The FNP called for physician consultation for any patient who had complex or acute medical problems, or whose condition appeared terminal. She took first call for the SNF patients, I took second, and the physician on call for our group took third.

In addition to her patient care responsibilities, she became involved with administrative tasks such as in-service teaching, discharge planning, obtaining paraprofessional services for patients, record keeping, and attendance at utilization review meetings.

We feel that our patients benefit most by the greater amount of time the nurse practitioner is able to spend with them. Each patient is helped to feel important as a person and is given time to express symptoms, feelings, fears, and questions. The FNP takes time to discuss with patients the rationale for a suggested regimen. In short, reduction of time pressure allows a more humanistic approach to this patient group.

Patients also benefit from the absence of an "I-thou" relationship which may unintentionally be generated when physician and patient are involved on a one-to-one basis. The FNP is greeted as often by a hug as by a handshake. She is an inveterate optimist whose conviction that each patient can improve is contagious.

A frustrating aspect of patient improvement is the re-classification of patients from skilled to intermediate levels of care, which sometimes results in their transfer to other facilities, often against their wishes. Even within the skilled nursing classification, however, patients are making improvement I was previously unable to obtain or recognize. By no means do all, or most, patients make the dramatic improvements of the examples we will cite, but an impressive number do. In attempting to determine what differences in care were responsible for the significant gains made by these patients, we submit that the team approach allows time for each component of patient health care to be identified, considered, and pursued by the FNP with her "care" oriented background and reviewed by the physician from his "cure" orientation.

Medications are not only reviewed on each visit, but also discussed with the patient and nursing staff to achieve maximal therapeutic response with the minimal number of medications. Over-medication is considered first as an explanation for untoward change in patient status. Nursing care plans are continually updated as improvement occurs or new patient problems develop. Restorative services are employed whenever possible and reconsidered as patient improvement permits. Personal contact with the restorative aide or physical therapist not only facilitates communication, but the "strokes" delivered in the exchange also involve the therapist more personally in the progress of the team's patient. These contacts allow intercourse regarding rehabilitation potential and specific attention to be drawn to each patient's strengths, weaknesses, and new developments that suggest progress that may be further pursued.

Dietary consultation by the FNP may include weight reduction to make walking a more realistic goal or to reduce the pain from arthritic, weight-bearing joints. The patient's dentition and neurologic status are considered and every possible consideration is given to patient food preferences and cultural background that might influence the adequacy of dietary intake. Each patient is started on multi-vitamins, as it has been our observation that failing appetite and limited food budget frequenty result in a diet high in carbohydrates and inadequate in vitamins.

Psychosocial aspects are explored at the time of the initial assessment with particular attention given to how the patient views self and his desires, needs and goals. For example, Mrs. W has been bedfast for two years and required a Hoyer lift for transfer. Her major goal was to stand and walk. To make this possible, a reduction diet was started; physical therapy which the patient had previously refused was begun; and the nursing staff organized a step-by-step plan with a series of attainable goals. The patient learned to stand for five minutes using a walker for support and, though unable to walk, was able to transfer from bed with the assistance of aides. This improvement made it possible for her to go home for overnight visits with her family. Though she has since died, her family still expresses gratitude for the progress she was able to make.

Frequently the FNP encounters grief, despair, and anger. Sometimes, the patient's goal is to die. The FNP encourages venting of negative feelings while supporting and reinforcing anything that can be used as a handle to start rebuilding the patient's self-esteem. Sometimes, the anger and hostility a patient vents can serve as such a handle. Mrs. L, though withdrawn and in the fetal position, was characterized by her sister as never having been a "quitter." The FNP, armed with this information while visiting the patient, demanded to know why she had suddenly become a quitter. A small voice responded, "I'm not a quitter!" Mrs. L climbed out of bed that night, has not resumed the fetal position, walks between parallel bars, and enjoys visiting her family.

If significant others are involved with the patient, they are enlisted as allies in helping the patient reach a therapeutic goal. All patients are coerced to participate in any activity, consistent with physical limitations, that will provide stimulation and social interaction. We feel that sensory deprivation may be a commonly missed explanation for confusion in reclusive old people. Orientation to time and place may be an inadequate tool for evaluation of one whose friends are all dead; whose scope of life has narrowed to a room, a mailbox, and a grocery store; and whose failing health has resulted in transport to a hospital and later to a SNF where passage of time becomes meaningless.

Every patient is evaluated for potential discharge. Re-evaluation for discharge when it becomes more feasible is an ongoing process that is pursued when the FNP makes her monthly visits. When discharge is a possibility, community resource persons are recruited to help prepare the patient for transition from the hospital to the community and to provide the services needed to maintain the patient within the community.

The involvement in all of these aspects of patient care often takes less time to accomplish than to describe. The FNP may be discussing a patient with the director of nursing when they are approached by a restorative aide. The resulting conversation, lasting no more than five minutes, could result in changes in several patients' care plans for restorative services. The key to these miniconferences is the availability, accessibility, and flexibility of the FNP and her contact with the physician member of the team.

Benefits of Team Approach

The following cases are illustrative of the kinds of improvement we have been able to obtain within our patient group using the principles outlined applied by a "care-cure" team. Mrs. C became our patient on transfer from an acute-care hospital. She arrived with the diagnoses of atrial fibrillation, insulin-dependent diabetes, and post-cerebrovascular accident with left hemiparesis. She was somnolent and the transferring physician considered her restorative potential to be poor. Observation of minimal responses suggested some restorative potential to the FNP and physical therapy was started. The patient had supportive family members who were included in her care plan. Under the physician's supervision, medications were adjusted and the atrial fibrillation stopped while the diabetes was brought under control. The patient continued to make progress in physical therapy and can now walk with the aid of a tripod cane. She is completely oriented and recently told the FNP team member an amusing story dealing appropriately with current events.

Another patient, Mr. M, came to the SNF totally confused, bedfast, and incontinent. He now reads, is alert, walks, and has been reclassified. A third patient, Mrs. C, was confined to a wheelchair and bed and had incessant complaints. Her complaints were reduced to her neuralgia, and she again walked without assistance. Before her death, her emotional tone was optimistic and she felt pride in her progress.

Our greatest therapeutic triumphs are the patients who improve enough to go home. Mrs. J, for example, was admitted from the acute-care hospital bedfast, psychotic, and incontinent. Six months later, she was discharged walking, oriented, and able to perform daily activities with minimal assistance. She now attends weekly YMCA exercise group and helps with the household chores.

Mr. R. had liver decompensation from cirrhosis and was totally confused, non-ambulatory, and incontinent. He was diagnosed as an insulin-dependent diabetic. He now enjoys reading, gives himself his own insulin, has abstained from alcohol while released on several visits home, and, with the help of a medical social worker, is being reintegrated into the community.

The patients profit from several technical aspects of our team approach. Patients' needs are more quickly met because of the FNP's mobility. Their problems are considered from two points of view and two backgrounds. The FNP team member, from her nursing experience, considers nursing roles in patient care more carefully than I was able to do, and her consideration results in improved communication with nursing staffs in the facilities.

We serve the families of the SNF patients by discussing care and treatment of their elders. We try to help them work through their feelings of guilt and grief and accept the mortality of their relatives. Our support and reassurance sometimes make more acceptable the painful decision to place a loved one in a long-term care facility when home care is no longer possible.

Benefits to the SNF are more tangible than those to the patient or family. SNF administrators are reprimanded by inspectors if patients are not visited at prescribed intervals and if annual updates of physical assessments are not done in a timely fashion. We are able to relieve the SNF administrators of that problem with our patients. The accessability of the FNP improves communications, so SNF personnel feel more secure than when working with a physician whose availability is uncertain. Also, employees of SNFs are required by law to have an annual physical examination, a function we perform for all six facilities. Finally, teaching services are provided in each facility by the FNP.

I benefit from working with a nurse practitioner because I

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feel comfortable about the quality of care our patients receive. Combining our abilities in caring and curing seems especially useful when caring services may be the lion's share of what we can offer many patients. Without a physician extender, I was stressed to care for 50 SNF patients; as a team, we provide better care for 250. Interruption of my days off is rare, and I am almost never called by the SNFs at night. Though early in our relationship the FNP and I spent a great deal of time together working out policies, protocols, and procedures, we now share only two lunch hours a week discussing new patient work-ups and patient problems. To be sure, there are frequent hallway consultations and occasionally some by telephone, but my own expenditure of time is considerably less than that required to care for 50 SNF patients by myself. One of the greatest conveniences is being able to send the FNP team member to a SNF for assessment of an urgent problem while I stay behind to care for patients waiting in the office. Finally, more time can be spent with each patient and better communication with patient, family, and SNF staffs provides a broader data base for problem identification and treatment.

Some Problems

I have emphasized the positive aspects of a team approach to elder care. There are also some problems. If a patient, who has not been visited by a physician within 20 days dies, the death is automatically a coroner's case, even though the patient's passing may have been anticipated. To reduce the incidence of this problem, I make a special effort to see any patient who is failing, even though the visit may add little to his overall medical care.

Because of the use of telephone order forms to assure prompt countersigning of orders initiated by the FNP, a constant stream of paper flows between my office and each SNF. The stream is larger now than before I worked with a nurse practitioner because of increasing the number of patients we supervise by 500 percent. Each month, I make a special trip to each SNF to sign the monthly order review and countersign each of the FNP's progress notes.

A minor, but annoying problem, is that of limited office space. The addition of another working person to a space already fully occupied requires understanding and good humor on both sides. This problem is diminished by a record-keeping system that is portable and concise and that allows me to keep current on patients and the FNP to work anywhere that she can find a phone.

Other Issues

Quality assurance for the services provided by the team is a subject that lies at the crux of evaluation of the quality of team care in the SNF. The team concept involves not only the physician and nurse practitioner, but also other members of the health-care community and provides a built-in system of checks and balances for attaining the goal of effective patient care. The physician member of the team is presently medical director of all SNFs in Fremont. In that role he is a continuous contact with the administrator and nursing staff of each facility. Any problems arising in patient care are freely and frequently discussed. Monthly chart review requiring cosignature of physical assessments, progress notes, and therapeutic recommendations offers additional opportunity for monitoring quality of care. Frequent medication reviews by the facility pharmacist serve as another check on appropriateness of therapy.

The problem of compensation is one that deserves consideration. The FNP team member started work at a salary lower than that usually paid nurse practitioners, and lower than she had been offered elsewhere. She was started at $1,200 monthly plus 25 percent of the net proceeds from her productivity. In the year we have worked together, our patient load has increased from 50 to 250, but she has received neither bonus nor raise in salary. Our family practice group has underwritten the expense of hiring a FNP. At this point, cash received approximately equals expenses, but we have accounts receivable from Medicare and Medi-Cal which, if collected at the rate prevailing so far, should yield $10,000 to $12,000. Clearly this form of health-care delivery is not a moneymaker in the beginning, but we are confident of a reasonable profit in time.

The chief problem is one of which the reader is probably well aware. Our office has collected only 37 percent of our total gross billing for team services in the SNFs because of the delay of the agencies in payment. Of the accounts for which we have been paid, we have collected 65 percent and must write off 35 percent. It is apparent that the lower overhead associated with a nurse practitioner is of benefit when trying to make financial sense of skilled nursing patient care.

Comment

In short, there exist a host of reasons that make physicians reluctant to care for SNF patients on the traditional fee-for-service basis. The drawbacks of a team approach are far outweighed by the advantages of this form of health-care delivery. The patients receive far more attention and time, the physician's time is spent much more efficiently, and the SNFs are aided by better compliance with regulations and better communication between the nursing staff and the nurse practitioner. We feel the team approach to care for skilled nursing patients is a most workable and effective solution to a prevalent problem.

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HOWS, WHYS AND WHEREFORES OF GRANTSMANSHIP IN AGING

Coordinator; Phoebe S. Liebig, Admin. Analyst/Planner, Andrus Gerontology Ctr., USC, Los Angeles, CA.

Resource Persons: Daniel Fritz, Ph.D., Asst. Prof., Gerontology & Public Administration, USC, Los Angeles, CA; Deborah Newquist, M.S.W., M.P.A., Dissemination Asst., Social Organization & Behavior Lab, Andrus Gerontology Ctr., USC, Los Angeles, CA; Raymond M. Steinberg, D.S.W., Proj. Dir., Social Policy Lab, Andrus Gerontology Ctr., USC, Los Angeles, CA.

Recorder: Joyce Olson, Aging Services Coordinator, Minot, ND.

Private and public sources provide funding for projects in aging. Private funding occurs mainly through foundations including corporations with set aside funds, private individuals, family foundations, community foundations or trusts that are multiple donor sources pulling together small donors to promote welfare of the community in which they are based, and company-sponsored foundations disbursing the company's annual gift which may be restricted to giving to the factory community. There are 50,000 foundations, mostly small. These usually are short staffed and need short, clear funding proposals.

Federal funding is the second source of program resources. The federal grants process has developed since World War II, originating in war contracts. It is still a contract system and contract law also applies to grants. It does not exist for the government to help us, but to help the government do its work. From the AoA perspective, grant funding is a human process with rational and irrational aspects. Three to four hundred proposals have to be processed in a very short time.

PROPOSAL:

The grant writer should remember that the readers know nothing about you or your State. Do not assume anything; state everything clearly. If a proposal is junky or hard to read, the readers will disregard it; so to be considered, the application should be clear, with no unnecessary jargon. Answer the question asked; do not try to show off what you know instead. Study the criteria and follow it: respond to all criteria as there is a point system and you lose points by not responding. Be sure to follow application instructions and to use the suggested form.

An abstract is essential. In some agencies this is sent to the review panel for a preliminary review, so spend time and effort on your overview. The responsibility of communicating is on the communicator: ask yourself if someone who knows nothing about your program makes sense out of the grant request. Have an objective third party read your proposal to check it for clarity. Use the "tell them what you are going to tell them and tell them what you told them" technique. Make it clear to the funding agency what they are buying with the money you request.

Use double spacing for all narrative material. Provide pagination and an index for easy reader access to all grant components. Remember that, physically, problems emerge when handling hundreds of proposals. Protect your proposal by binding it, enclosing it in a cover of some sort.

PREPARATION:

Decide exactly how you will use the money you are requesting. Set up linkages with other service components: the supportive coalition you build will depend on what you want to accomplish. Get support but decide the degree to which you want to let others in the field know what you intend to do; your interest in a potential program may stimulate competition. Do accurate public relations in the community: it is a given fact that people are down on what they are not up on, and you need community support.

Do your homework to be aware of similar projects being developed in your area. After researching the field describe the state of the art, emphasizing who is being underserved. Determine if there is any other agency available to provide the service you are considering in your proposal. Determine who your target groups are: i.e., those needing policy-relevant technical assistance, or the older people themselves. Establish in the beginning who will use your program and how they will find out about it, as well as the effect this will have, and tie this research into your evaluation. Use demographics that you have developed to support your request.

SPONSORING AGENCY:

Face the auspice issue and determine exactly who is to be fiscally accountable. Outline past experience as evidence that your auspice is best able to provide the service. Emphasize your access to the target population and the resources you can draw on to serve them. Describe the ability your auspice has to carry on your program when funding ends or the opportunity you have to get established institutions to continue the program after short-term funding terminates.

DISSEMINATION:

More and more government grantors are requiring outreach, so that the people who should use the service will know about it. Stress transmission of information to potential consumer groups. Include some members of your target group in your planning as a lead to them, to save time and money. Determine when the target group is to get the information about your project. Consider your time and skills, and the money available. Describe the method you intend to use, whether it is to be fliers, mailings, media, purchased public relations, cassettes, slides, films, journal publications, or a summary-finding brochure. Budget this in, know what you want to do and what it will cost.

Establish that what you intend to do is deliverable; that you are tying dissemination or outreach into evaluation, that you will determine who used the information or service you provided, why they did or why they didn't.

BUDGET CONSTRUCTION:

Do a precise needs analysis, and trim all budget fat. For a three or five-year plan, however, project inflation based on how much items such as paper or typewriters, for example, have gone up. In planning travel costs, project mileage increases because of the rising cost of gasoline. In computing staff salaries, raises should be built into the program to assure retention of trained staff. Be sure that your budget is adequate and does not allow the new program to drain the internal resources of your agency.

Community resources, individuals or organizations, should not be expected to provide services without receiving something from your grant, either released time, mileage or some other reimbursement for services rendered. What they are going to receive for their contribution to your program should be decided before your proposal is written.

Long-range planning is essential. How are you going to find supplementary sources of funding to continue when the federal program ends? This should be worked out during the three year life of your program.

Be aware that multiple funding means multiple headaches. Accounting for a budget interlocking 20% of each person on 5 separate grants can absorb a great deal of bookkeeping.

BUDGET JUSTIFICATION:

Clarity is essential in budget justification. To establish credibility you have to leave nothing UNCLEAR. Ascertain shipping charges and exact expenses for equipment, explain why you need it. And have someone with expertise edit your budget justification, to assure clarity.

EVALUATION:

Every proposal should have a built-in mechanism for feedback. The evaluation or accountability factor is essential, and should be integral to the proposal. Your objectives should be measurable, and your evaluative process should be firmly in view as you develop your proposal.

AoA MODEL PROJECTS IN THE WEST

Coordinator. Marvin J. Taves, Ph.D., Chief, Div. of Research Applications and Demonstrations, Admin. on Aging, Washington, D.C.

Recorder: Mary Shenefield, Executive Secretary, Wyoming Senior Citizens, Inc., Riverton.

Dr. Taves commented in opening the meeting that priorities in his division remain basically the same with new emphasis being placed on social models of day care as opposed to health care and projects designed to deal with unique problems of minorities (including non-English speaking and rural). The problem of requests exceeding funds still exists and the basic difference between proposals that are funded and those that are not funded is innovation. The following Model Projects were described with an explanation by the director as to what makes them a "model."

Juana Lyon
NATIONAL INDIAN COUNCIL ON AGING, INC.
P.O. Box 2088
Albuquerque, New Mexico 87103
(505) 766-2276
Ms. Lyon explained that the problems of Indian elderly are new because of the changed veneration. A National Indian Conference on Aging held in June of 1976 led to an expression of the need for legislative changes and to promote communication and coordination for Indians with similar interests. A National Indian Task Force evolved and the follow-up action was funded. Advocacy for the Indian and Alaska Native elderly is the overall purpose with specific objective to bring about the remedial action recommended at the National Indian Conference on Aging. A detailed overview of the recommendations was distributed. The uniqueness of their project is in dealing with 500 separate Indian tribes each with its own language, religion, culture, etc., while safeguarding the Federal commitment to Indians.

Marie-Louise Ansak
ON LOK SENIOR HEALTH SERVICES
1490 Mason Street
San Francisco, California 94133
(415) 989-2578
On Lok Senior Health Services was explained in a film presentation. Community concern for the welfare of frail elderly, specifically those of Chinese, Filipino, and Italian background who do not speak English, led to this alternative to premature institutionalization. Services offered include transportation, meals, counseling, therapy, medical screening and monitoring, podiatry, recreation, personal care, sheltered housing and consultation in psychiatry, dental, hearing, eye, and legal. Its uniqueness is in helping these frail elderly to continue living in their familiar surroundings.

A professional team composed of a social worker, physician, nurse, therapists, and dietician evaluates each applicant and re-evaluates participants. This intake and assessment staff develops the treatment plan along with the applicant, private physician, family and friends. The socio-medical treatment center is the component offering the actual services. PING ON is the social-health maintenance center for participants whose medical needs are not acute. Recreational and educational programs, hot meals and consultation by a nurse and a podiatrist are offered. Persons pay according to ability.

Carroll L. Estes
PROJECT IDEA: UCSF
3835 Mission Street
San Francisco, California 94110
(415) 824-1664
Project Idea is a comprehensive and systematic model for collecting, classifying, and disseminating nationwide data about innovative programs, legislation, and policies in the field of aging. PROJECT IDEA grew out of a pilot project, "Developments and Trends in Aging" and addresses the need of professionals, governmental bodies and organizations serving elders for rapid sharing of new ideas and developments. Its uniqueness is in the communication networks that describe innovative activities, identify resource people, provide access to timely information, link decision-makers, promote pooling of experience, and facilitate innovation diffusion.

Dolores Davis
NATIONAL CENTER ON THE BLACK AGED
1730 M Street, NW, Suite 811
Washington, D.C. 20036
(202) 785-8766
The primary concern of NCBA is the socio-economic needs and welfare of aging and aged Blacks. A network of chapters devoted to the needs of Black elderly is being organized as well as a cadre of professional and non-professional workers trained in organization, advocacy, program planning, and negotiation skills being developed. Specific activities include employing older persons on projects related to the goals of the Environmental Protection Agency, managing an anti-victimization project, providing an experimental transit program, improve service delivery among fragmented district-based social agencies, develop a senior housing complex, expose minority faculty to the operations, facilities, and curricula of several major gerontology centers, design certificate and undergraduate programs oriented to service delivery, offer a student internship program, prepare position papers on research priorities for Black elderly, solicit unpublished documents by minority scholars, establish Job Bank Service, develop legislative positions to produce legislation that will improve living conditions for Blacks, and sponsor workshops.

Cail House
HOMEMAKER SERVICE AIDE PROGRAM
College of Home Economics, Box 4170
Texas Tech University
Lubbock, Texas 79409
(806) 742-3033
Promoting a service that will match homemakers wanting jobs with older citizens needing some help is the goal of the Homemaker Service Aide Program in a 15-county rural area of West Texas. The service provides quality, in-home care services of meal preparation, personal care, home management, escort service, visitation, and companionship for the elderly. Persons over 60 are thus enabled to function in their own homes. Employment, para-professional training, and

opportunities for mature, underemployed homemakers is a second benefit. The uniqueness of this project is in its two-edged approach and the geographic dimension of the area served.

U. Vincent Manion
COMMUNITY PRERETIREMENT/TRAINING INSTITUTE
North Texas State University
Department of Community Service
Denton, Texas 76201
(817) 788-2181

The intent of this community education/training model project is to broaden the availability, the quality, and the delivery of preretirement preparation services in five target communities. Its uniqueness is in its community-wide approach to deal with the problem of the availability and delivery of preretirement services, and the training of individuals within the community to take the lead in the development or delivery of such programs and services. How are community leaders found? How are they effective? What accounts for it? The community as a system is often a passive recipient of fragmented pressure-based actions. The alternative being tested is that a planned system-wide community effort to train leaders in planned change is more effective. A five-phase operation of problem exploration, knowledge exploration, priority development, program development, and program evaluation are the focus of the workshops. What the community's responsibility to make services available and how the community can plan for change then evolve.

Theodore Ruhig
LA COOPERATIVA CAMPESINA DE CALIFORNIA
State of California Migrant & Seasonal Farmworkers Council
800 Capitol Mall, Room 5039
Sacramento, California 95814
(916) 322-6100

"A Statewide Bilingual Response to the Needs of the Migrant Elderly" is to demonstrate to present service delivery systems in the State of California that, without vast new resources, there are feasible and practical ways to assist an "invisible" population of elderly citizens - the ex-migrant and seasonal farmworker. A bilingual statewide Information and Referral Service is being developed. Also, some of the data being collected during the development phase will help fill a statistical and planning gap in the field of aging in order to identify the nature and scope of the problem confronting low-income retired farmworkers in California.

Peter Corning
COMMUNITY SERVICES COOPERATIVE
334 North 2nd Street
San Jose, California 95112
(408) 967-2291

Using a critical area of need to first organize, this Community Services Cooperative is demonstrating organizational rather than technical innovations. The key element is having a catalyst functioning in a new social role which combines the direct provider into other roles which is being called "social service broker." Being tested is whether or not the "social service broker" is a role which can be justified, the degree to which self-help can be an approach, and what the cost-reduction in services might be. Although transportation is the service most critically needed, other self-help activities are coordinated: food-buying club, reduced-cost medicine buying club, neighbor "skill-swaps," where persons exchange goods or services needed by others in return for what they need.

AGE SIMULATION THROUGH GAMING

Coordinator: Elizabeth Falor Bexton, M. Arch, Co-Director, SAGE and Gerontological Facilities, Inc., Berkeley, CA.

Recorder: Patricia Grinager, Ph.D., School of Nursing, Univ. of Wisconsin, Milwaukee.

Everybody in this game reads directions first. Following some minor verbal explanations, some participants find themselves as elderly with varying capabilities so far as concerns their health, money, relationships, and/or transportation. A handful of players become police or social agency workers who forthwith aid or hinder the ability of the elderly to alleviate their problems. Fate, represented by the chances inherent in the toss of dice, betters or worsens the living conditions of the oldsters even further: a player can become blind or be put in a section of the room designated as Intensive Care. Should a player run out of money or relationships, he or she must go sit in the seats designated as The Cemetery.

Each playing of this game differs from its predecessors because the personalities of the players make varying circumstances occur. One learns about being older by experiencing the actual exasperations of having little or no health or money or relationships or transportation and by trying to wriggle one's way through these difficulties without going under.

In the discussion that followed the game, participants shared what it felt like to be cast in the role of an older person with the gamut of predicaments elderly commonly experience; of police, with sometimes disagreeable jobs to do; of social workers or agency people, who become frustrated as they attempt to establish workable policies while listening to incessant requests for aid. The best and the worst came out in role players during the game. Everyone seemed to make special efforts to help the blinded player. Those who got the most money from the agencies were the very ones who had hung around the longest asking for it. Even the police ripped off a player who died.

All in all, this game is a most effective way to understand quickly what it's like to be elderly and/or to be working in a situation in which a number of them desperately cope.

AGE SIMULATION THROUGH GAMING

Coordinator: Elizabeth Falor Bexton, M.Arch, Co-Director, SAGE and Gerontological Facilities, Inc., Berkeley, CA.

Recorder: Thomas C. Timmreck, Ph.D., Asst. Prof. of Community Health and Health Education, Texas Tech Univ., Lubbock.

Workshop participants were given instructions and participated in the role playing experience to build empathy with situations faced by and coping strategies used by many older persons.

THE GAME:

END OF THE LINE is a simulation game based on living patterns familiar to many older persons in the United States. The game assumes that it is perfectly natural for people to live diverse lives and equally natural in time for them to die. The game has been developed particularly for those persons who either by profession, training or accident find themselves working with, ministering to, or planning for the aged. For most players in the game, survival is a measure of success, and maintaining life will depend partly on skill and adaptive responses to situations that develop during play, and partly on blind luck.

BACKGROUND:

For many years evidence from older people, their friends and relatives, and from various research efforts and professionals' experience has indicated that in retirement few older people find the good easy life they had expected would be theirs. The effects of a series of wars, the Depression, continual inflation, changes in family living patterns, and acceleration of cultural change have made those dreams difficult to materialize. Yet, the vast majority of older persons in this country have coped with the situation and are doing quite well, considering the circumstances. END OF THE LINE is particularly concerned with these persons, with their interactions with other aged persons, and their interactions with several members of the community.

ZESTFUL LIVING FOR TODAY AND TOMORROW—
PHYSICAL REHABILITATION PROGRAMS

Coordinator: John P. Farber, M.S.W., Coord. of Rehabilitation Services, Spalding Rehabilitation Ctr., Denver, CO.

Resource Persons: E. Howard Boardman, B.S., Dir. of Food Service, Service Direction, Spalding Rehabilitation Ctr., Denver, CO; Barbara Boutell, B.S., O.T.R., Dir. of Occupational Therapy, Spalding Rehabilitation Ctr., Denver, CO.

Recorder: Peg Hatfield, Director, Linn County Retired Senior Volunteer Program, Albany, OR.

This workshop delineated problems of the elderly incapacitated by strokes, arthritis and other debilitating conditions and the avenues of aid available.

The same standards of nutrition are applicable to the aging with the exception of caloric requirements which decrease with age. Obesity as a problem is far more severe in the elderly. Often under-nourishment is the real problem with those who live alone or can no longer shop or cook for themselves.

Often many elderly return home after strokes and other catastrophies. Moving about and the fear of falling are threatening. Generally there are no funds to remodel a home to accomodate the disabled, but means can be found to help them assume the homemaker role in the case of women.

Analysis of their previous role was recommended as well as consideration of the role of other members of the household in the new regime. A plan should be set up and tasks assigned. Let the homemaker be the decision maker, the meal planner, if the capacity for further work is lost. Organization and training of others to help was suggested.

Psychological and social needs in regard to nutrition were considered and plans for work simplification and energy conservation offered. Homemaking techniques were given for the arthritic, the stroke victim, those with visual defects and the cardiac patient.

THE DAVIS INSTITUTE FOR THE CARE AND STUDY OF THE AGING

Coordinators: A. J. Kauvar, M.D., President & Eric Pfeiffer, M.D., Acting Dir., The Davis Institute, Denver, CO.

Resource Persons: Joan Allen, Short-Term Training Coordinator, The Davis Institute, Denver, CO; Fred Dudden, M.L.S., Gerontology Resource Librarian, The Davis Institute, Denver, CO.

Recorder: Betty L. McMeekin, M.S. Candidate in Aging, North Texas State University, Denton.

This special interest session served to introduce and inform the participants regarding the Davis Institute for Care and Study of the Aging.

A review of the conceptual history included Martin Davis' desire to make a beneficial contribution to mankind. Program considerations were: what is going to help the greatest number of people in the next 10, 15, 20 years; what is going to make the greatest impact on the system. These considerations along with what one man had experienced and learned working with people during his active professional career resulted in the founding of the Davis Institute.

The Davis Institute is a multi-disciplinary research center and will serve as a focal point for training in gerontology and the care of the aged. The facility will have a library with books ranging from professional to political as well as large print books and recordings for the blind.

GOALS relating to aging in the broadest sense with PROGRAMS designed to make the Institute the focus of knowledge about the field of aging in the Rocky Mountain region include:

CLINICAL SERVICES - from outpatient geriatric evaluation center; to independent living center to relearn capacity for living in the community; and to inpatient unit for intensive evaluation and acute care of the more seriously ill.

RESEARCH - from basic biological research and how medications effect the elderly; to the relationship of older persons to other members of their families; and to studies of pre-retirement procedures in industry.

EDUCATION - from catch-up training for professionals on problems on the elderly; to the development of curricula and educational materials for use in educational programs; and to public forums on aging for the elderly and their families.

Through one man's generosity, another person's thought, a need of society, and a problem of natural origin of interest to everyone, the Davis Institute for the Care and Study of the Aging was founded to benefit all mankind.

THE EVOLVING ROLE OF GERONTOLOGISTS IN MUNICIPAL GOVERNMENTS

Coordinator: Jeanette J. Dutton, Coord., Senior Citizens Services, Dept. of Human Services, Garden Grove, CA.

Resource Persons: Ken Cameron, Asst. Dir., City of Seattle Division on Aging, WA; Carolyn Sullivan, Planner, Aging Services Division, Portland, OR; Kate Wilbur, Asst. Coord., Field Work, Leonard Davis School of Gerontology, USC, Los Angeles, CA.

Recorder: Roberta V. Ebert, Senior Citizen Coordinator, Dept. of Parks and Recreation, Corvallis, OR.

There are 171,000 people age 60 or over in Seattle and of these, 25 per cent are at the poverty level and 40 per cent represent the target population, reports Ken Cameron. The Seattle aging program is sponsored by the city, the county, and the United Way. The staff is paid through the City of Seattle.

In Oregon, 18 per cent of the total population of people age 60 and over live in the Portland area. This serves as a powerful advocate block for political issues. Portland has a lobbyist in Washington, D.C. and in the State of Oregon working for the political interest of the Portland elderly. Carolyn Sullivan identified the Portland Area Agency on Aging as having a role in both the city and county. Both agencies fund the Area Agency programs on a 50/50 basis. It is through the fifty neighborhood associations that the Area Agency contracts serve. It is the policy of Portland social services to act as a broker of services.

The Department of Human Services is the location of Aging Services of Garden Grove, Orange County, California. A seven-person advisory board of senior citizens serves as a sounding board for the aging services. A professional is hired full time to do needs assessments, to plan and develop programs, to administer services, and to do community organization. In the last three years the aging service role has evolved to developing private agencies to provide services for senior citizens.

Kay Wilbur identified the role of the gerontologist as program developer, training specialist, developing resources, and with the legal responsibility to develop a coordinated system of services with the existing social service providers. The gerontologist's role is to improve the quality of life for the older person.